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Queen of Canada

Elizabeth the Second, by the Grace of God of the United Kingdom, Canada and Her other Realms and Territories, Queen, Head of the Commonwealth, Defender of the Faith.

SUCH IS THE ROYAL STYLE and title accepted by our parliament for use in Canada, and to each citizen its every word is rich with meaning. In accordance with the development of constitutional relations, Her Majesty is now Queen of Canada because she is Queen of the United Kingdom, and because the people of Canada are happy and proud to recognize as their sovereign the person who is the sovereign of the United Kingdom.

It is a recognition of the traditional development of our institutions that our parliament be headed by a sovereign. It is fitting that the recognition be retained in the title as a proclamation of the link between this country and the United Kingdom.

An event of great importance, change in the royal style and title is a responsibility always undertaken by parliament. Alterations have been made periodically through the ages as the concept of government has changed. The title of the first sovereign of the United Kingdom was King of the English, established by King Egbert in the ninth century. A thousand years ago, King Athelstan adopted the title of King of Britain and Henry VIII added Defender of the Faith. Later changes were made necessary by the act of union with Ireland, the inclusion in the British Empire of India and of the British dominions beyond the seas. One of the abiding qualities of the present title is its freedom from any suggestion of pomp or boastful pride —it is simple, moving and direct.

But it is not in the name nor title of the sovereign that the strength of our country consists; not in constitutions or unification under a central authority that the Commonwealth is strong and vital; rather, it is on the development of our common memories, shared ideas and unified purposes that the quality of our country and the Commonwealth depends. We the nurses of Canada have, through our national association, offered our allegiance to Her Majesty on the occasion of her Coronation. In a message bearing the C.N.A. crest the nurses

of Canada "present our humble duty and have the honor to send loyal greetings from nurses who have a real sense of your dedication to the welfare of your peoples to the service of mankind."

Ours is the privilege of having inherited the parliamentary system of government and of being part of the great commonwealth of nations—an effective instrument for the good of free man throughout the world. It must be our concern to see that our acts, thoughts and attitudes uphold and sustain the high purposes, ideals, character and traditions of the Commonwealth, as symbolized in the royal person of Her Majesty—The Queen of Canada.

God Save the Queen!

What Do We Owe?

IT IS A WELL KNOWN axiom in social work that free services are rarely appreciated as much as those for which a fee is asked—be it ever so small. Is it not equally true that the things we value most in this life are those requiring some measure of return from us? This willingness—this urge to give in return for benefits received—is the measure of our maturity, our sense of personal integrity and self-respect.

It cannot be denied that nursing gives its practitioners some of the richest rewards possible, and it is our duty—no, our privilege—to make what return is in our power. What are these rewards given by the nursing profession to its members? Ask yourself that question, and see if some answers don't come thronging into your mind without effort, so obvious are they.

There is the deep personal satisfaction felt by every nurse who is rendering a service to people. This is one of life's most precious commodities, which many less favored persons seek in vain, while it is given freely to all who practise nursing. There is the constant gratitude of patients and their families. Who among us has not been moved by the expressions of gratitude that often follow us through the years, and of which many of us feel undeserving? Very often it is not due to any personal quality on the part of the nurse, but it is a tribute to the profession she serves. There is, too, the prestige of belonging to an honored profession. What other vocation for women is there, except the other healing professions, that carries the same degree of public respect? Also, the healing professions give their members a large measure of personal adequacy in many life situations. In learning the skills and attitudes of nursing one develops a knowledge and confidence that enables one to take command of almost any situation. Others recognize this fact, and rely on nurses for leadership in many fields.

These are just a few of the assets we acquire from the mere fact of being nurses. Should we not give serious thought to the debt we owe to the profession in return? We can find no better example for this recognition of an obligation than in the life and death of the late Dowager Queen Mary.

Her acceptance of the role of Queen meant innumerable self-imposed duties, which, though by no means easy, she scorned to shirk. In her stern obedience to the demands of her high position; by her immaculate example and invincible virtue; by her rigid code of behavior in private life as well as in public, Queen Mary meticulously discharged her obligation to the responsibilities of royalty.

Our own responsibilities to our profession, though less exacting, should be nonetheless real. The profession demands from its members an active, enlightened interest and participation in its affairs and management. How

better can this obligation be met than by regular, thoughtful reading of the professional journals; considered contributions to them; and the conscientious attendance at meetings for the free expression of opinion?

It is expected of us that in our efforts to free nurses from the limitations of tradition-bound thinking and outworn sentiments, we should not lose sight of our ultimate objective. Thus there should be no large-scale effort on the part of nurses to ease their lot, without a crusade pressed with equal vigor to improve the quality of care given to the patients.

In our awe of the advances made by science, and of new discoveries in medicine, there is a tendency to overlook the contribution that has always been made by good nurses and doctors. It is a major responsibility of professional nurses that they practise the *art* as well as the science of nursing—that they maintain and preserve the personal integrity of all whom they serve and with whom they work. Though science has changed the things done for the patient it has not changed his basic need. He still requires some one person who will care for and about him—who will be concerned about his fears and his worries, and to whom he can talk and be understood and accepted. To meet this basic necessity we *must* develop that reverence for life that is the antithesis of materialism—that materialism that seems to be gaining ground in the world today.

In these ways we can, at least partly, discharge our debt to the profession we have chosen, and which yields the utmost in personal fulfilment to its members. Let each one of us see to it that, on her part, this debt is discharged fully and gladly. It is only in this way that our profession will grow to a majestic ideal of service, and we ourselves develop a spiritual stature in keeping with that growth. —C.W.P.

Find the Twins!

An unusual feature of the capping service held on March 15 at the General and Marine Hospital, Collingwood, Ont., was the fact that two sets of twins were among the 12 students to take part in the ceremony. Margaret Masters, the director of nurse education, presented the girls who were received into the school by Amy White, the superintendent. Dr. R. Storey addressed the students on their responsibilities and the place they must take in their profession. On behalf of the Board of Directors, Mr. J. Smart, the president, extended a welcome. Marion Malcolm, Student Body president, presented them with their caps. They also received copies of white-bound Testaments from the Ladies Auxiliary of the Gideon Society.

Left to right: D. Rigney, B. Weatherall, Margaret and Mary Ransier, Jean and June Lavers, M. McLean, A. Clugston, A. Turner, B. Wiley, D. McMillan, J. Culham.

Civil Defence Casualty Services

K. C. Charron, M.D.

Civil defence health service plans are based on the concept that if plans are developed for a major disaster and if these are flexible, then the organization will be able to cope with disasters of lesser magnitude. Even the largest metropolitan community in Canada would need considerable assistance to deal with problems created by an atomic burst and uniformity of basic planning is essential in order to permit effective aid. Plans must be thoroughly coordinated at all levels and civil defence health services must plan and train in peacetime against a wartime emergency.

Although casualty services constitute the largest single civil defence health problem, it must be remembered that there are other extremely important services which must be supplied. These include medical services for critically ill non-casualty cases, restoration and maintenance of public health services, organization of medical supplies, and other preventive and supportive services designed to minimize the health effects of mass disaster. The following article will deal with casualty services and is a digest of material prepared by a number of working parties which were set up to develop a general pattern for Canada.

Estimation of Number and Types of Casualties

One of the first steps in planning defence against atomic warfare is the estimation of the potential number and types of casualties and several variables need to be considered when local estimates are being made. Features such as the density of population in the potential target at different times in the day, whether adequate warning is likely to be received, fire hazards, and the shielding effects of buildings and hills will all affect casualty estimation and must be taken into consideration when local planners are preparing detailed plans for a particular area. Despite these and other variables, it is considered that the overlay principle of estimating casualties will assist civil defence authorities to make a rapid assessment of the situation and to deploy available resources to a disaster area. This overlay principle is illustrated in *Fig. 1* and is described briefly as follows:

A series of population density maps is prepared for the area, showing maximum and minimum density hours. Transparent overlays are prepared to the same scale, with a hypothetical ground zero and concentric circles at one-half mile intervals. Within these circles are percentages indicating casualty percentages with or without warning. These percentages are based on the probable effects of an air burst of a nominal atomic bomb and tables are available with revised percentages for bombs with a greater TNT equivalent.

Thus the civil defence director would obtain information as soon as possible after the attack as to the approximate location of ground zero and, by applying the appropriate overlay, would be in a position to estimate the probable casualties and the best routes of ingress for first aid and rescue parties. Detailed information received later would permit a more accurate deployment but this method allows for rapid and effective initial action.

An atomic air burst can cause casualties from blast, heat, and radioactivity. Of the living casualties, it is estimated that about 60 per cent would be suffering from burns, 50 per cent from mechanical injuries, and 20 per cent from radiation. Many would have more than one type of injury, which is the reason that the total is over 100

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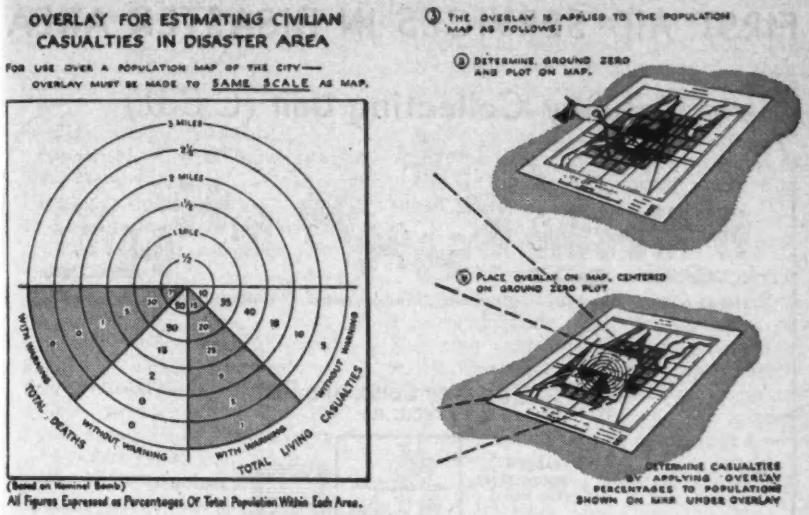

Fig. 1

per cent. One-third would have minor injuries, one-third moderate, and the remainder severe. In an average Canadian city, it is possible that such a burst would cause 40,000 or more casualties and the pattern for civil defence casualty services has been worked out to meet disasters of this magnitude.

First Aid Services

The first aid services would consist of the personnel, equipment, and transportation required for: (1) casualty collecting units which provide first aid care in the devastated area and (2) first aid stations set up on the circumference of this area. Each first aid station (F.A.S.) would have three casualty collecting units working with it and would be designed to handle approximately 1,000 casualties. In addition, the principle of self-help would be stressed and first aid would be available also at warden's posts, welfare centres, and from industries, department stores, and so forth, that have set up first aid units as a part of their pre-disaster planning. It is estimated that first aid services might have to deal with 20,000 or more casualties following an air burst of a nominal atomic bomb and the arrangements suggested are intended for such a situation. It is emphasized, however, that the disposition of first aid services would depend on the type and magnitude of the disaster and arrangements must be flexible to allow for alternate methods of deployment.

Mobilization of First Aid Services

Assembly points should be established outside a potential target area, usually near the outskirts of a city. These assembly points will serve as storage locations for first aid supplies and as meeting points for personnel and transport assigned to the first aid services.

First aid service personnel should proceed to their assigned assembly points immediately after a disaster and alternate assembly points should also be designated. The first aid vehicles would also rendezvous at these points, pick up first aid supplies and personnel, and then be directed to the approximate location of the first aid station. The exact site of the first aid station would be determined in consultation with the local warden service after arrival at the incident site and control headquarters would then be in-

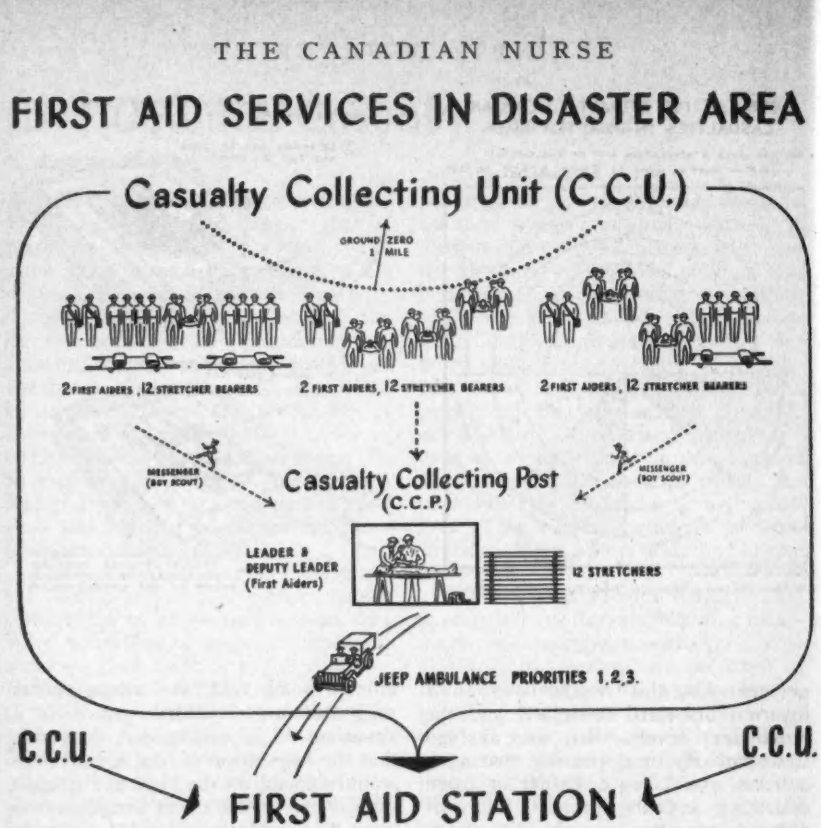

Fig. 2

formed of this location. Casualty collecting units attached to the first aid station would work forward from this site.

Mutual aid area units and mobile support columns should be familiar with the basic pattern for first aid arrangements. They would stop at assembly points on the way to obtain directions concerning their assignment to particular locations. These mobilization plans would have to be integrated with those of other civil defence services and all first aid service personnel must be thoroughly familiar with them.

Casualty Collecting Units (C.C.U.) (*Fig. 2*)

Functions of a casualty collecting unit. The C.C.U. will carry out the following functions:

(a) Control hemorrhage.
(b) Immobilize fractures.
(c) Apply dressings to wounds.
(d) Treat burns.
(e) Relieve pain.
(f) Initiate record on the emergency medical tag.
(g) Transport stretcher cases and direct walking wounded to first aid station.

Personnel for a casualty collecting unit. Each casualty collecting unit will have the following personnel and three units will work with each first aid station:

Unit leader	1
Deputy unit leader	1
Messengers	2
First aiders*	6
Stretcher bearers*	36
	46

*(3 teams with 2 first aiders and 3 stretcher parties of 4 bearers each)

Equipment for a casualty collecting unit.

FIRST AID KIT

Bandage, gauze, compressed, 4" x 5 yds.	ea.	12
Bandage, muslin, triangular, compressed, 40" x 40" x 56"	ea.	6
Shell dressing		10
Pins, safety, medium, 12's	card	1
Morphine tartrate syrette, 0.016 (¼ gr.) 1.5 cc. collapsible tube with needle	ea.	6
Tetracaine ophthalmic ointment 5% ⅛ oz. in tube	ea.	1
Emergency medical tag, 50's	book	2
Pencil, lead, medium, with eraser	ea.	1
Pencil, colored wax	ea.	1
Scissors, stretcher bearer, 6"	ea.	1
Pouch, canvas, with carrying strap (for first aid kit)	ea.	1
Water bottle	ea.	1

These kits will be issued to the unit leader, deputy leader, first aiders, and to the senior person in each stretcher team.

Stretchers—1 per team, with blankets—(Pool of 12, with blankets, at C.C.P.).

Operation of a casualty collecting unit: Three casualty collecting units will be attached to each first aid station and will cover the part of the damaged area considered to be the responsibility of the particular unit. They will work in from the circumference towards ground zero. Damage control officers and others on the spot will supply information on the location and number of casualties likely to be found in the area and assist with the proper deployment of the units. However, the units will be under the direct authority of the physician in charge of the parent first aid station. Each unit will proceed along an assigned route and the leader of the unit will set up a casualty collecting post (C.C.P.) as far forward as jeeps or other light vehicles at the disposal of the unit are able to proceed. The objective will be to reduce the distance of the stretcher carry to a minimum. The first aid and stretcher teams will fan out from the C.C.P. and examine, treat, and tag casualties. They will work closely with the rescue services and exchange stretchers with that service if stretchers allotted for rescue are used to transport victims. The unit leader and his deputy will operate at and out of the C.C.P. and they will have two messengers at their disposal. A stretcher pool of 12 stretchers, with blankets, will be established at the C.C.P. Walking wounded may be treated in the forward area, at the C.C.P., or be directed to the first aid station.

FIRST AID STATIONS (*Fig. 3*)

The first aid station units are mobile in the beginning and then take up a static location with the casualty collecting units operating in advance of the fixed station and working closely with it. It is at this level that casualties first come under the care of medical personnel and receive emergency medical treatment.

Functions of a first aid station will be as follows:

(a) Control hemorrhage.
(b) Immobilize fractures.
(c) Apply dressings to wounds and burns.
(d) Triage (screening).
(e) Treat shock.
(f) Relieve pain.
(g) Maintain casualty records.
(h) Hold casualties (if evacuation cannot be accomplished at once).
(i) Keep Medical Controller informed.

Personnel requirements and staffing pattern for a first aid station:

Medical officers	4
Dental officers, pharmacists	3
Nurses	6
Nursing auxiliary and first aid workers	60
Transport officers	3
Clerks	6
Stretcher bearers	50
Canteen worker	1

The above represents the personnel required to operate the first aid station for a 24-hour period. In certain target areas it may not be possible to staff fully the first aid stations with local personnel. In such a case a nucleus group would be provided from local resources and they would rely on mutual aid and mobile support to bring the staff up to full complement.

One of the four physicians should be designated as the Officer-in-Charge of the first aid station and a second named

as his deputy. Physicians should screen and sort casualties, direct the treatment of patients and personally supervise the treatment for the most urgent cases.

Dentists should serve as administrative officers and as medical assistants, supervising and carrying out emergency treatment which might include the giving of anesthetics, venipuncture, and so forth.

Pharmacists in the unit would be particularly valuable in handling supplies and assisting with emergency treatment.

One of the six nurses should be designated as the Nurse-in-Charge. The primary function of nurses in first aid stations would be to supervise the work of auxiliary nursing workers. They might also be called upon to do venipuncture and perform other duties which are ordinarily considered to be beyond the responsibilities of their profession in normal times.

The auxiliary nursing workers should be trained in advanced first aid and/or home nursing. Certain selected individuals should receive training in special procedures, such as giving in-

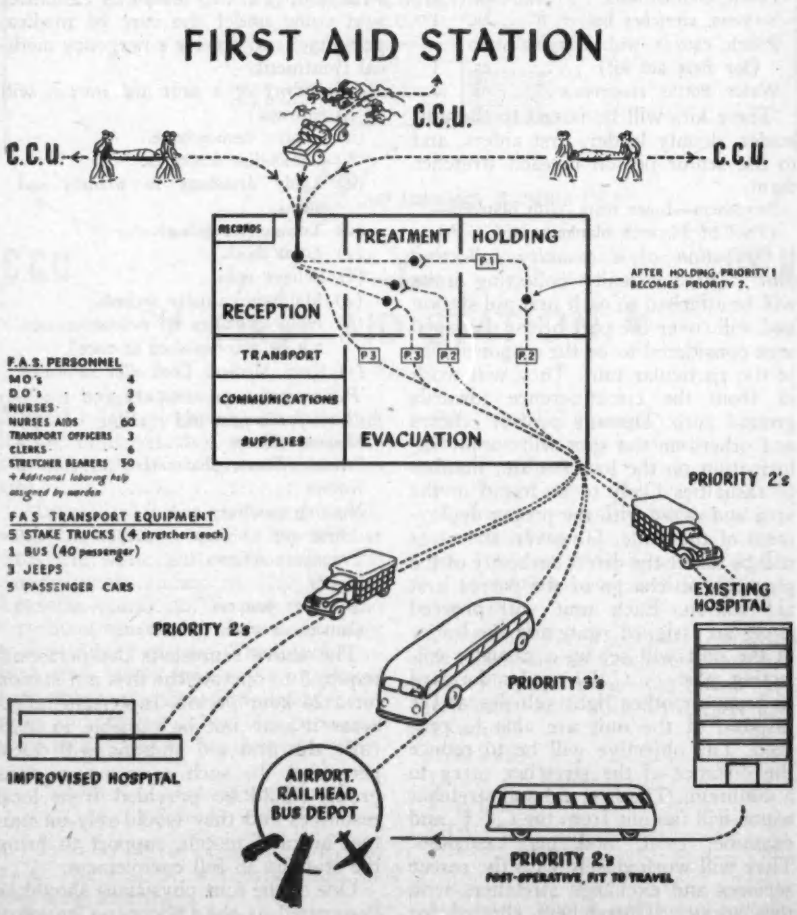

Fig. 3

jections, venipuncture, and other duties which are ordinarily considered to be beyond the experience of this group.

Transport officials would have operational control of the vehicles allotted to the first aid station. They should arrange for a few of the lighter vehicles to proceed forward and move casualties from the casualty collecting posts to the first aid stations. The remainder of the vehicles would evacuate casualties from the first aid stations to the emergency hospitals. Transport officers should act as liaison officers between the Medical Officer in charge of the first aid station and the Medical Controller at the sub-divisional control centre.

Clerks would be responsible for records. They should see that the emergency medical tag is completed in the reception area of the first aid station for all casualties. The entry in the first aid station log should also be completed before the casualty leaves the first aid station and this information should be obtainable from the emergency medical tag.

Stretcher bearers in the unit would assist with the setting up of the first aid station, carry patients, and do other heavy work as required.

The canteen officer would be seconded from the welfare service and should provide hot drinks and other nourishment for both the casualties and staff.

Equipment for a first aid station: The detailed list of equipment is too long for inclusion in this article. It contains the instruments, drugs, and dressings required for 1,000 casualties and allows for the holding of up to 200 of these for a period of up to 24 hours. However, a few items might be mentioned — plasma, plasma substitutes, and glucose and saline will be provided for fluid therapy; penicillin in oil and oral penicillin as antibiotics; cellulose pads as burn dressings; and Thomas splints, Kramer wire, and plaster of paris for fractures.

Operation of a first aid station: It is desirable that all casualties flow through a first aid station (*Fig 3*). The casualty is checked in the reception area, the diagnosis made, and classification into one of three priorities is effected.

PRIORITY 1

Cases requiring resuscitation and urgent surgery.

Severe shock from whatever cause.
Open wounds of the chest.
Abdominal wounds.
Very extensive muscle wounds (calf, thigh, buttocks, axilla).
Severe open fractures.
Severe burns.
Certain multiple wounds.

PRIORITY 2

Cases requiring early surgery and possibly resuscitation.

Less serious open fractures.
Multiple minor wounds.
Less serious amputations.
Less serious burns.

PRIORITY 3

All other wounded cases.

Walking casualties would be treated and sent to their homes or to rest centres to return, if necessary, for outpatient service. Cases requiring operative and other skilled professional care would be transported immediately, if possible, to an emergency hospital and speed of evacuation would have priority. However, the time lag between the first aid station service and care in an emergency hospital may make supportive treatment necessary at the first aid station for such priority cases. Other less urgent cases may also have to be held at the first aid station until evacuation could be arranged. Plans should be made for the holding of up to 200 casualties for a limited period at each first aid station.

HOSPITAL SERVICES

Hospitals would be the focal points for civil defence casualty services and would be essential for definitive care, particularly for the seriously injured. If an atomic bomb exploded over one of our Canadian cities, at least 20,000 persons would need hospital care and a considerable proportion of these would be seriously injured. It might be possible to evacuate a proportion of the injured outside of the target and mutual aid areas but a large percentage would have to be accommodated within the area and cared for by local hospital

facilities that would be of three types:

(a) Existing hospitals that were still usable.
(b) Improvised hospitals set up in suitable buildings.
(c) Hospitals in surrounding areas.

Possible targets in Canada present many variables when hospital potential is being considered. The number of existing hospitals in the community which might be available following an attack can only be determined by a local study of hospitals and their distribution in relationship to the probable target. It is obvious, when thinking in terms of 20,000 persons requiring hospital care, that the majority would have to be treated in improvised hospitals and it would be impossible to furnish normal standards of care.

Existing hospitals: In the event of disaster, hospital facilities would be reserved only for the most seriously injured. As a first step in meeting the situation, advance arrangements should be made for evacuation of all hospital patients who could be moved on the threat of an impending attack or immediately after an attack. These patients should be discharged to their homes, to centres providing convalescent care, or to remote hospitals. Experience indicates that 75 to 80 per cent of the patients in hospital on any particular day could be evacuated and make room for the seriously injured.

The hospital should determine ways and means to expand to the greatest possible capacity and the average general hospital can be expanded considerably, sometimes to twice or even three times normal capacity. This could be accomplished by using all available space, including conference rooms, classrooms, storage rooms, corridors, and other areas. Expansion plans should also include arrangements for using adjacent buildings which are considered suitable for the purpose. However, overexpansion of the hospital should be guarded against, and it must be remembered that the basic facilities and staff should be able to handle the numbers and types of casualties anticipated for the particular unit.

In order to provide for uniform planning, a hospital disaster plan kit has been prepared to assist individual hospitals to set up emergency programs which could be integrated into an over-all hospital disaster plan for all levels. A pamphlet entitled "Hospital Services and Casualty Records" has also been made available to explain the procedure suggested in the kit.

The staffing of hospitals, particularly with professional personnel, would present a major problem and most areas would end up with staff deficits. Arrangements would be made for these deficits to be made up from surrounding areas or more distant points. Similarly, plans have been formulated to have essential medical supplies stockpiled on a regional basis in locations where they could be brought rapidly to potential disaster areas.

Improvised hospitals: Since existing hospitals would be able to care for only a small fraction of casualties from a major civilian wartime disaster, plans to utilize non-hospital buildings as hospitals must be prepared in advance. The steps in a preparedness plan are illustrated in *Fig. 4*. In general, it is considered that schools and similar buildings offer the most satisfactory type of structure for conversion to

Fig. 4

emergency hospital use because they are uniformly distributed, offer a large amount of floor space, have essential facilities such as heat, electricity, hot and cold water, extensive toilet facilities and, in most cases, lunchrooms and kitchens. They have wide corridors, adjacent playgrounds, and are of one- or two-story construction. However, a preliminary survey of each area should indicate the buildings which might be converted into hospitals. This preliminary assessment should be followed by a detailed appraisal of each building by a survey team composed of a hospital administrator, an experienced surgeon, and a hospital matron.

Hospitals in surrounding areas: As soon as possible, patients should be transferred from improvised hospitals to nearby or existing hospitals. Local civil defence health service directors should consult with provincial authorities in regard to facilities in other areas that might be used to supplement the hospital resources of the particular community.

Hospitals outside the disaster area might also be expected to provide mobile teams to assist with the staffing of units within the devastated city and hospital plans have to be flexible to meet this type of situation. An affiliated unit might be composed of 20 members, headed by a unit director. The table of organization might include the following:

1 Chief of medical services.
1 Assistant chief of medical services.
6 General duty medical officers.
(It is considered desirable that at least half of these general duty medical officers have had considerable surgical experience.)
1 Chief of surgical services.
1 Assistant chief of surgical services.
2 Anesthetists.
(It may not be possible to obtain fully qualified anesthetists in the numbers required and this classification also includes physicians with considerable anesthetic experience.)
8 Nurses.

Affiliated units would be called to duty as required and assigned to existing, improvised, or regional hospitals. The unit described is of convenient size to transport by air. Similarly, small specialist teams might also be needed and plans are being formulated to provide neurosurgical, maxillofacial, and ophthalmic groups. Other specialist groups might also be required.

Conclusion

This article describes the pattern for civil defence casualty services in Canada. Emphasis is placed on the need for flexible planning and arranging for adequate mobile support. It is only by a complete mobilization of resources at all levels that we could hope to cope with disasters created by modern methods of war. In addition, any organization built up to meet a wartime necessity would be extremely valuable in coping with any major disaster which might arise in peacetime.

Twins Beget Twins

On any one day in Canada, 10 to 30 sets of twins may be born but only those who timed it right could claim the Westinghouse Award. March 17, 1953, was the lucky day!

To the parents of every set of twins born in Canada on that day, the Canadian Westinghouse Company presented a set of "laundry twins"—a new 1953 Westinghouse Laundromat and the new Westinghouse Automatic clothes dryer.

The Dominion Bureau of Vital Statistics estimated the likely number of twin births for that day as 12, but nature more than doubled that number, there being 30 sets of twins and one set of triplets born on Mar. 17.

We wonder — will the parents of the triplets be awarded an ironer as a mark of recognition for their extra product?

* * *

To prevent disease it is necessary to create an environment rather than to give a dole where there is no opportunity for money to modify the condition of the recipient. —Sir Robert McCarrison in "Nutrition and Health"

* * *

Pleasure is satisfaction of libido, but contentment comes from its control.

Services de la Défense Civile à l'intention des Victimes

K. C. Charron, M.D.

Les services de la défense civile à l'intention des victimes reposent sur le principe que si l'on conçoit des plans, bien souples, pour un grand désastre, on pourra affronter des désastres de moindre importance. La plus populeuse localité métropolitaine du Canada elle-même requerra une aide considérable pour régler les problèmes suscités par une explosion atomique et, pour avoir une aide efficace, il faut une élaboration fondamentale uniforme. Les plans doivent se coordonner minutieusement à tous les échelons; les services des victimes à la défense civile doivent s'organiser et s'entraîner dans la paix contre les calamités de la guerre.

Les services des victimes constituent sans doute le plus grand problème de la défense mais il ne faut pas oublier qu'il y en a d'autres, extrêmement importants, à fournir. Ces derniers comprennent les services médicaux pour les grands malades non victimes, la restauration et l'entretien des services d'hygiène publique, l'organisation des fournitures médicales, et les autres fonctions préventives et protectrices destinées à réduire les mauvais effets des grands désastres sur la santé publique. Le présent article porte sur les services des victimes; c'est un résumé préparé par un certain nombre d'équipes particulières qu'on a établies afin d'élaborer un système général pour le Canada.

Estimation du Nombre et des Genres de Victimes

L'une des premières mesures, dans l'élaboration de la défense contre la guerre atomique, consiste à prévoir le nombre et les genres de victimes. Il y a plusieurs facteurs variables à considérer, quand on effectue les estimations locales. Les particularités telles que la densité de la population aux différentes heures du jour dans une cible virtuelle, la probabilité d'un avertissement convenable, les risques d'incendie, les propriétés masquantes des bâtisses et des collines, influent sur le calcul, et les organisateurs locaux doivent en tenir compte lorsqu'ils dressent les plans détaillés pour une localité particulière. Malgré ces variantes et d'autres, on croit que la méthode des transparents pour l'évaluation du nombre des victimes aidera les autorités de la défense civile à inventorier avec rapidité la situation et à déployer les ressources disponibles dans la zone atteinte. Ce principe, illustré à la *Fig. 1* (page 439), se résume ainsi:

On prépare pour la zone une série de cartes indiquant les heures de densité démographique maximum et minimum. On prépare des transparents à la même échelle, avec un hypothétique point zéro du sol, et des cercles concentriques situés à un demi-mille d'intervalle. Dans ces cercles se trouvent inscrits les pourcentages des victimes avec ou sans avertissement. Ces pourcentages se basent sur les effets probables causés par l'éclatement d'une bombe atomique nominale et il y a des tableaux à pourcentages revisés pour les bombes de plus grande puissance explosive.

Ainsi le directeur de la défense civile apprendra le plus tôt possible après l'attaque l'endroit approximatif du point zéro et, par l'application du transparent approprié, se verra en mesure de déterminer le nombre probable de victimes et les meilleures routes d'accès pour les escouades de secourisme et de sauvetage. Les renseignements circonstanciés reçus plus tard permettront un déploiement plus exact

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Ceci est le premier d'une série d'articles du numéro spécial du *Canadian Medical Association Journal* sur la Défense Civile qui seront publiés avec la permission de l'Association Médicale Canadienne.

mais cette méthode rend plus rapide et efficace l'action initiale.

La bombe atomique fait des victimes par l'explosion, par la chaleur et par la radio-activité. Parmi les victimes vivantes, on estime qu'environ 60 p. 100 souffriront de brûlures, 50 p. 100 de blessures mécaniques, et 20 p. 100 de radiation. Plusieurs auront plus d'un genre de blessures, raison pour laquelle le total dépasse 100 p. 100. Un tiers auront des blessures légères, un tiers des blessures modérées, et le reste, des blessures graves. Dans une ville canadienne moyenne, il se peut qu'une telle explosion entraîne 40,000 victimes ou plus et l'on a organisé les services de la défense civile à l'intention des victimes de manière à faire face aux désastres de cette ampleur.

Services de Secourisme

Les services de secourisme se composeront du personnel, du matériel et des moyens de transport requis pour: (1) le lieu de rassemblement des blessés où l'on donne les premiers soins dans la zone dévastée; et (2) les postes de secourisme établis à la circonférence de cette zone. Chaque poste de secourisme (P.S.) aura à son service trois unités de rassemblement des blessés et sera organisé de façon à traiter environ 1,000 victimes. En outre, on insistera sur le principe de l'aide personnelle; les premiers soins se donneront aussi aux postes des gardes civils, aux centres de bien-être, aux usines, aux grands magasins et autres établissements, qui ont établi des unités de secourisme comme partie de leurs préparatifs. On estime que les services de secourisme auront à traiter 20,000 victimes et plus après l'explosion d'une bombe atomique nominale; les arrangements conseillés s'appliquent à une telle situation. On souligne toutefois que la disposition des services de secourisme se subordonnera au genre et à l'ampleur du désastre; il faut des arrangements assez souples pour permettre plusieurs méthodes de déploiement.

Mobilisation des Services de Secourisme

On établira des points de rassemblement en dehors de la région-cible virtuelle, en général à la périphérie de la ville. Ces points serviront à emmagasiner les fournitures de premiers soins et à rassembler le personnel et les transports affectés au secourisme.

Le personnel des services de secourisme se rendra à son point de rassemblement aussitôt après le désastre. On désignera aussi des points alternatifs de rassemblement. Les véhicules du secourisme iront à ces points, recueilleront les approvisionnements appropriés et le personnel, puis se dirigeront vers le lieu approximatif du poste. L'emplacement exact de ce poste se fixera en consultation avec le service local de garde civile après l'arrivée au lieu du bombardement et l'on fera alors connaître cet endroit au quartier général de contrôle. Les unités de rassemblement des blessés attachées au premier poste de secourisme partiront de là.

Les unités des régions d'aide mutuelle et les colonnes de renfort mobile devront connaître à fond le modèle fondamental des arrangements secouristes. En chemin, elles s'arrêteront aux points de rassemblement pour recevoir les directives concernant les endroits où on les affectera. Il faudra incorporer ces plans de mobilisation à ceux des autres services de la défense civile et tout le personnel de secourisme devra les bien connaître.

Unités de Rassemblement des Blessés (U.R.B.) (*Page 440*)

Fonctions: L'unité de rassemblement des blessés aura les fonctions suivantes:

(a) Arrêter les hémorragies.
(b) Immobiliser les fractures.
(c) Panser les plaies.
(d) Traiter les brûlures.
(e) Soulager la douleur.
(f) Commencer l'inscription sur l'étiquette médicale.
(g) Transporter les cas de brancard et diriger les blessés vers le poste de secourisme.

Personnel: Chaque unité de rassemblement des blessés aura le personnel suivant et trois unités travailleront avec chaque poste de secourisme:

Chef d'unité 1

Sous-chef d'unité	1
Messagers	2
Secouristes*	6
Brancardiers*	36
	46

*(3 équipes de 2 secouristes avec 3 escouades de 4 brancardiers chacune).

Matériel pour une unité de rassemblement des blessés.

Trousse de Secouriste

Bandages de gaze comprimés, 4 pouces sur 5 verges	12
Bandages comprimés triangulaires de mousseline, 40 po. sur 40 sur 56	6
Pansements de grandes dimensions	10
Epingles de sûreté, moyennes, carte de 12	1
Syrette de tartrate de morphine, tube pliant de 0.016 (¼ gr.) 1.5 cc. avec aiguille	6
Onguent opthalmique de tétracaïne 5% ⅛ once, en tube	1
Etiquettes médicales, blocs de 50	2
Crayon moyen avec gomme à effacer	1
Crayon de couleur, en cire	1
Ciseaux de brancardier, 6 po.	1
Sac en toile à courroie de support (pour trousse de secouriste)	1
Sac d'eau chaude	1

On remettra une de ces trousses au chef d'unité, au sous-chef, aux secouristes et au doyen de chaque escouade de brancardage.

Brancards—1 par escouade avec couvertures (groupement de 12 avec couvertures au P.R.B.).

Fonctionnement de l'unité de rassemblement des blessés: Trois unités de rassemblement appartiendront à chaque poste de secourisme et desserviront dans la zone endommagée la partie considérée à leur charge. Elles travailleront à partir de la circonférence vers le point zéro. Les officiers contrôleurs des dégâts et autres sur place feront connaître l'endroit et le nombre des victimes probables dans la zone et aideront au bon déploiement des unités. Ces unités seront cependant sous l'autorité directe du médecin en charge au principal poste de secourisme. Chacune suivra une route désignée et son chef établira un poste de rassemblement (P.R.B.) aussi en avant que les jeeps et les autres véhicules légers en service là pourront aller. L'objectif consistera à réduire au minimum la distance du transport par brancards. Les équipes de secourisme et de brancardage rayonneront du P.R.B. et examineront, traiteront et étiquetteront les victimes. Elles travailleront en coopération étroite avec les services de sauvetage et échangeront avec eux des brancards, si les brancards affectés au sauvetage servent au transport des victimes. Le chef de l'unité et son adjoint dirigeront au poste et en dehors et ils auront à leur disposition deux messagers. Un groupement de 12 brancards s'établira au P.R.B. Les blessés qui peuvent marcher pourront se faire traiter dans la zone avancée, au poste de rassemblement, ou se diriger vers le poste de secourisme.

Postes de Secourisme

Les postes de secourisme, mobiles au début, se fixent ensuite; et les unités de rassemblement travaillent en avant du poste et en coopération avec lui. C'est à cet échelon que les victimes obtiennent les premiers soins médicaux et le traitement de secours.

Fonctions d'un poste de secourisme:

(a) Arrêter les hémorragies.
(b) Immobiliser les fractures.
(c) Panser les plaies et les brûlures.
(d) Faire le tri.
(e) Traiter le shock.
(f) Soulager la douleur.
(g) Tenir les dossiers des victimes.
(h) Garder les victimes, si l'évacuation ne peut avoir lieu aussitôt.
(i) Tenir renseigné le contrôleur médical.

Personnel requis et modèle pour un poste de secourisme:

Médecins	4
Dentistes, pharmaciens	3
Infirmières	6
Assistantes-infirmières et secouristes	60
Agents de transport	3
Commis	6
Brancardiers	50
Cantinier	1

Ce qui précède constitue le personnel requis pour diriger un poste de secourisme pendant une période de 24 heures. En certaines régions-cibles on ne pourra peut-être pas doter les postes de personnel local; en ces cas-là, on

organisera à même les ressources locales un noyau et on demandera à l'aide mutuelle et au renfort mobile de compléter.

On nommera premier médecin un des quatre du poste et on lui donnera un adjoint. Les médecins trieront et classeront les victimes, dirigeront le soin des malades et surveilleront personnellement le traitement des cas les plus urgents.

Les dentistes serviront comme administrateurs et comme aides des médecins; ils surveilleront et exécuteront le traitement improvisé, qui peut comprendre l'anesthésie, les ponctions veineuses et le reste.

Les pharmaciens de l'unité se révéleront surtout précieux dans le maniement des approvisionnements et dans l'aide au traitement improvisé.

Il faut nommer directrice une des six infirmières. La fonction primaire des infirmières, dans un poste de secourisme, consistera à surveiller le travail des infirmières auxiliaires. On pourra aussi leur demander de faire les ponctions veineuses et d'autres travaux considérés en général au delà de la responsabilité de la profession en temps normal.

Les infirmières auxiliaires requièrent une formation en secourisme avancé ou en soins, à domicile. Certaines personnes choisies recevront la formation en fonctions spéciales, par exemple les injections, les ponctions veineuses et autres fonctions jugées d'ordinaire au delà de leur capacité.

Les agents du transport dirigeront la circulation des véhicules assignés au poste de secourisme. Ils s'organiseront pour que quelques véhicules légers avancent, prennent les victimes aux postes de rassemblement et les conduisent aux postes de secourisme. Les autres véhicules transporteront aux hôpitaux improvisés les victimes évacuées des postes de secourisme. Les agents du transport serviront comme officiers de liaison entre le médecin en charge au poste de secourisme et le médecin contrôleur au centre de contrôle sous-divisionnaire.

Les commis auront la responsabilité des dossiers. Ils verront, pour toutes les victimes, à faire remplir l'étiquette médicale dans le lieu de réception du poste de secourisme. L'inscription au journal du poste de secourisme devrait aussi se faire avant que la victime quitte l'endroit, et ce renseignement paraîtra sur l'étiquette médicale.

Les brancardiers de l'unité aideront à établir le poste de secourisme, à transporter les malades et à effectuer les autres lourds travaux requis.

Le cantinier recevra l'aide du service de bien-être et fournira les breuvages chauds et d'autre nourriture aux victimes et au personnel.

Matériel pour un poste de secourisme: La liste détaillée du matériel est trop longue pour paraître dans le présent article. Elle renferme les instruments, les drogues et les pansements nécessités par 1,000 victimes et fait entrer en compte la garde de jusqu'à 200 parmi elles pendant une période d'au plus 24 heures. On peut pourtant mentionner quelques articles: plasma et succédanés du plasma, solutions glucosées et salines, fournies pour la thérapeutique par liquides; pénicilline dans l'huile et pénicilline en comprimés, comme antibiotiques; pansements cellulosiques, contre les brûlures; éclisses Thomas, fil métallique Kramer et plâtre fin, pour fractures.

Fonctionnement d'un poste de secourisme: Il convient que toutes les victimes passent par le poste de secourisme (*Fig. 3*—voir à la page 442). Le point de réception identifie la victime, pose le diagnostic et la classe dans l'une des trois catégories prioritaires.

1ERE CATEGORIE

Cas exigeant réanimation et chirurgie urgente.

Shock sévère de toutes causes.
Plaies ouvertes à la poitrine.
Plaies à l'abdomen.
Très grandes plaies aux muscles (mollet, cuisse, fesse, aisselle).
Graves fractures ouvertes.
Brûlures graves.
Certaines blessures multiples.

2EME CATEGORIE

Cas exigeant prompte chirurgie et peut-être réanimation.

Fractures ouvertes moins sérieuses.
Petites plaies multiples.
Amputations moins graves.
Brûlures moins graves.

3EME CATEGORIE

Toutes les autres blessures.

Les victimes qui peuvent marcher seront traitées et envoyées chez elles ou aux centres de repos, pour revenir, s'il y a lieu, au service externe. Les cas nécessitant des opérations ou autres soins professionnels spécialisés seront transportés aussitôt, s'il se peut, à un hôpital provisoire. L'évacuation rapide a la priorité. Le laps entre les soins au poste de secourisme et les soins à l'hôpital provisoire peut cependant obliger ces cas de priorité à un traitement d'appui au poste de secourisme. D'autres cas moins urgents devront peut-être aussi rester au poste de secourisme jusqu'à ce qu'on puisse organiser l'évacuation. On s'organisera donc de manière à pouvoir loger jusqu'à 200 victimes à chaque poste de secourisme pour une période de temps limitée.

SERVICES HOSPITALIERS

Les hôpitaux constituent le point central des services des victimes à la défense civile; ils se révèlent essentiels au soin définitif, surtout des malades graves. Si une bombe atomique éclate sur une de nos villes canadiennes, au moins 20,000 personnes, en grande partie gravement blessées, requerront des soins hospitaliers. On pourra peut-être évacuer en dehors de la région-cible et de la région d'aide mutuelle une partie des blessés, mais la grande partie devra se loger dans la région et se soigner dans les installations hospitalières locales. De celles-ci, il y a trois genres:

(a) Les hôpitaux existants encore utilisables.
(b) Les hôpitaux improvisés dans des bâtisses convenables.
(c) Les hôpitaux des régions environnantes.

Les cibles virtuelles du Canada présentent maintes divergences, quand on considère le nombre de malades que peuvent admettre les hôpitaux. Le nombre des hôpitaux locaux qu'on pourra utiliser après une attaque ne se détermine que par leur étude sur place et par leur situation par rapport à ces cibles. Lorsqu'on parle de 20,000 personnes à hospitaliser, on sait fort bien qu'il faudra en traiter la majeure partie dans des hôpitaux improvisés et qu'il sera impossible de donner des soins normaux.

Hôpitaux existants: Dans un désastre, les commodités hospitalières se réserveront aux grands blessés. Comme premier remède à cette situation, on prendra des dispositions préalables pour évacuer dès la menace d'une attaque, ou aussitôt après l'événement, tous les hospitalisés qu'on pourra envoyer ailleurs. On enverra ces malades à leur foyer, aux centres de convalescence ou aux hôpitaux éloignés. L'expérience montre qu'on peut en tout temps évacuer de 75 à 80 p. 100 des hospitalisés et faire place aux grands blessés.

L'hôpital déterminera les moyens d'accommoder le plus grand nombre de blessés; l'hôpital général ordinaire peut connaître une grande expansion, parfois doubler, et même tripler sa capacité normale. On y arrivera en utilisant tous les espaces disponibles: salles de conférences, classes, entrepôts, corridors et autres. Les plans d'expansion comprendront aussi des mesures pour utiliser les bâtiments voisins jugés appropriés. Il faut cependant éviter la trop grande expansion et se rappeler que les commodités et le personnel réguliers devraient être en mesure de traiter le nombre et les genres de victimes prévus pour leur établissement.

Aux fins d'élaboration uniforme, on a préparé une trousse de documentation sur la tactique hospitalière dans les désastres, afin d'aider les hôpitaux à improviser un programme qui entre dans un système complet. On a aussi mis en distribution une plaquette intitulée "Services Hospitaliers et Dossiers des Victimes," afin d'expliquer la méthode conseillée dans cette documentation.

La fourniture de personnel, surtout de personnel professionnel, représentera un grand problème, et la plupart des régions finiront par manquer de personnel. On cherchera à remplir ces cadres à même les régions voisines ou les points plus éloignés. De même, on a dressé des plans afin de faire emmagasiner les fournitures médicales essentielles sur une base régionale en des lieux d'où elles puissent se transporter

rapidement vers les zones de désastre.

Hôpitaux improvisés: Comme les hôpitaux existants ne pourront traiter qu'un petit nombre de victimes occasionnées par un grand désastre civil en temps de guerre, il faut s'organiser à l'avance de manière à utiliser à cette fin d'autres bâtisses. La marche du plan de préparation se trouve illustrée à la *Fig. 4*. Règle générale, on consi-

Fig. 4

dère que les écoles et immeubles semblables offrent un genre satisfaisant de bâtiment pour la conversion en hôpitaux improvisés, car elles sont distribuées de façon uniforme, elles ont une grande surface de parquet, elles possèdent les commodités essentielles, telles que le chauffage, l'électricité, l'eau froide et l'eau chaude, plusieurs salles de toilettes et, dans la plupart des cas, des salles à manger et des cuisines. Elles ont de larges corridors, des terrains de jeu adjacents, un ou deux étages. Une enquête préliminaire, faite dans chaque zone, devrait cependant indiquer les bâtisses convertissables en hôpitaux. Ce relevé préliminaire sera suivi d'un inventaire détaillé de toutes les bâtisses par une équipe d'enquêteurs dont feront partie un administrateur d'hôpital, un chirurgien expérimenté et une première infirmière.

Hôpitaux des régions avoisinantes: Il faut au plus tôt transporter aux hôpitaux voisins ou réguliers les malades des hôpitaux improvisés. Les directeurs des services sanitaires locaux de la défense civile consulteront les autorités provinciales sur les commodités utilisables, dans les autres régions, afin de compléter les ressources hospitalières d'une localité donnée.

Aux hôpitaux situés en dehors de la zone atteinte, on pourra aussi demander des équipes mobiles pour aider à pourvoir de personnel les unités de la ville dévastée. Ce genre de situation exige de la souplesse dans les plans hospitaliers. L'unité affiliée se composera de 20 membres, sous un directeur. L'organisation comprendra à peu près les personnes suivantes:

1 chef des services médicaux.
1 chef adjoint des services médicaux.
6 médecins à service généralisé. On juge préférable qu'au moins la moitié de ces médecins aient une grande expérience de la chirurgie.
1 chef des services chirurgicaux.
1 chef adjoint des services chirurgicaux.
2 anesthésistes. On n'obtiendra peut-être pas en nombre suffisant les anesthésistes bien compétents, aussi cette catégorie englobe-t-elle aussi les médecins à grande expérience en anesthésie.
8 infirmières.

On convoquera, en cas de besoin, les unités affiliées et on les affectera aux hôpitaux réguliers, improvisés ou régionaux. Ces unités ont un effectif qui peut facilement se transporter par avion. On pourra aussi avoir besoin de petites équipes de spécialistes; on élabore des plans pour fournir des groupes experts en neurochirurgie, en traitement maxillofacial et en ophtalmologie. On requerra peut-être aussi d'autres groupes de spécialistes.

Conclusion

Le présent article a décrit le modèle élaboré pour les services canadiens des victimes, à la défense civile. On insiste sur la nécessité d'établir un système souple et d'organiser un bon renfort mobile. Ce n'est que par la mobilisation complète des ressources de tous genres que nous pourrons parer aux désastres créés par la guerre moderne. En outre,

toute organisation édifiée pour satisfaire aux exigences de la guerre se révèle très précieuse, si un grand désastre survient en temps de paix.

Some Paradoxes in Nursing

BERNICE E. ANDERSON

ON AUGUST 8, 1950, a feature article entitled "Mental Hospital has Convict Aids" appeared in *The New York Times*. This article reported that women from a reformatory were being used to care for mental patients. It described these women, who were serving terms from a few months to lengthy periods of time, as keeping watch over the mumbling patients for 12 hours a day six days a week. It was stated that "the women (prisoners) have benefitted greatly by the work."

On August 14 an editorial was printed which commented on the article. The title of the editorial was "Experiment in Penology." The practice of using convicts was hailed as a "truly pioneer experiment." Furthermore, the editorial continued, there seemed to be a "bond of sympathy between the prisoners and the patients."

No thinking citizens could raise objection to rehabilitation of prisoners, in fact, all would probably support it heartily, but it is inaccurate to call this a "truly pioneer experiment" from the standpoint of the patients. The care of patients by prisoners is something that nursing thought had been left behind in the 1800's. A quotation from *A History of Nursing*, by Adelaide Nutting, formerly director of the Division of Nursing Education at Teachers College, in describing the conditions found at Bellevue Hospital in 1873, reads:

> As far back as 1848 the system of convict nursing had been, in theory at least, discredited . . . Almost the entire staff of female attendants . . . was recruited from the class of petty offenders who had been "sent up," mostly for drunkenness, to the Island, and were called "ten-day women." If these, in the hospital service, showed any willingness to remain and keep sober, they were retained until their next "spree" and even such accidental mishaps were often overlooked if the "nurses" were at least kindly in their feelings for the sick, and this many of them—unless something happened to arouse their easily excited rage and violence—really were.

These articles in the *Times* illustrate one of the many paradoxes that exist in nursing and nursing education today. The average person's knowledge of nursing probably relates to the well advertised shortage more than anything else. The very discussion of shortage is somewhat paradoxical, for we have in the United States 1,170 state accredited schools of nursing which have developed since 1873. These schools admit about 44,000 students annually, have a total enrolment of about 100,000 and graduate about 25,000 annually. The total number of graduate nurses is about 500,000, 59 per cent of this number being in active practice. This is about 400 per cent more nurses than were available in 1910. The problem is not that there are fewer nurses available but that needs are expanding and new fields are opening up faster than the increasing numbers of qualified nurses can meet the needs.

NURSING SERVICE PROBLEMS

In the field of nursing practice are many problems that demonstrate fur-

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ther paradoxes existing today. One of these relates to the current hospital expansion program. Through assistance of Hill-Burton funds for hospital construction new hospitals are being built, new wings added, and the number of beds markedly increased. The development of veteran hospitals alone has been tremendous. From a theoretical standpoint this increase is of social benefit, for it is providing hospital facilities in areas where none has been available before and increasing facilities in areas where they have been inadequate. Furthermore, this increase is based on state-planning for hospital coordination, which is a real step forward. The paradox is this: in the process of expansion there is rarely any preliminary planning with regard to availability of nursing personnel needed for staffing, or budgeting for such staffing. The day a new hospital or wing is opened is usually the day someone begins wondering where the nurses are coming from, or it is assumed that the nurses who cannot meet the needs now will simply take over the new patients and somehow be able to care for them. The supply of nurses is not endless and planning for staffing should accompany planning for expansion.

A second paradox relates to the phenomenal expansion of hospitalization plans under the Blue Cross. These plans guarantee nursing care to the subscribers, at least during their hospital stay, but the guarantees are made without consultation or planning with nurses. What many patients are getting, therefore, is not nursing care but care by untrained or auxiliary personnel, although they have paid for and been guaranteed nursing care.

A third paradox has to do with the use of nurses as a human resource. Hospitals now constitute the fifth largest business in the United States. This is a tremendous investment and yet too little has been done to gear the services to meet the variations in nursing needs of patients. It is true that hospitals are more modern than formerly in structure and equipment, but we still use expensive professional nursing time for patients who do not need 24-hour hospitalization. A few hospitals are operating home care plans, whereby patients are on the hospital rolls and under hospital supervision while in their homes. Probably many patients could be cared for on a day-basis for tests and observations without the necessity of remaining in the hospital overnight. Nursing time saved thus could be used for those patients having need for continuous 24-hour care. Patients pay blanket rates whether they get little or much nursing care and ward patients needing constant care are usually not permitted, even at their own expense, to provide continuous nursing care for themselves, when in reality this should be provided by the institution because of patients' needs. Early ambulation is practised in hospitals with few facilities to make it possible for nurses to help patients assume increasing responsibility for their own care.

A fourth paradox relates to the way nursing care is given. Nursing care today is administered much as it has been during the past 75 years. The hours are not as lengthy, apparatus is more complicated, treatments are more time-consuming, but nursing is still done largely on a job basis. It is strange that this should be so when nursing is such an intimate personal service. In these days of emphasis on human relationships we still check on nurses by asking, "Have you taken all the temperatures? Have you given all the treatments?" We still frown on the nurse who spends any time in conversation with patients, which is, after all, the chief way to establish relationships with others. We still expect the nurse to stand on her feet the entire time she is with the patient and be active physically, doing things *to* the patient and his environment. How paradoxical this is now that we have recognized that the psychosomatic aspects of illness are so extensive and so significant!

A fifth paradox has to do with the functions of nurses. Hospitals, whose avowed aim is to render service to people, still do not place the individual to be served in the centre of their planning and operation. As institutions become more complex, more time is

spent on the mechanics of operation and of supplying physical facilities and comforts. As research in hospitals increases, the human element often becomes lost in tests, observations, and data. Traditionally, nurses have spent their time not only in nursing but in doing other routines and procedures. As the person who coordinates the services to the patient, the nurse devotes about 50 per cent of her time to the mechanics of providing services—ordering, checking, running errands, and so forth. Is it not paradoxical that the mechanics and routines should take precedence over the service to be rendered? The nurse needs time to know and help the patient and adapt the services to his needs. She needs to be free to centre her efforts on the nursing needs of the patient, not the jobs to be done. Simple and convincing as this may sound, its accomplishment will necessitate almost a major revolution in hospital routines and procedures, to say nothing of a change in philosophy.

Nursing Education Problems

Great as these paradoxes are in nursing practice, still greater ones exist today in the field of education for nursing. A notable one in education relates to control of nursing schools. It is surely a generally recognized fact that educational programs of all kinds should be located in, and controlled by, educational institutions. We prepare doctors, lawyers, teachers, plumbers, and all kinds of workers under educational auspices. Industries do not operate schools for the preparation of engineers; business houses do not conduct schools of business administration; drugstores do not prepare pharmacists; but all of these enterprises use such personnel. Is it not a paradox that in 1952, 90 per cent of the schools of nursing were operated by consumers of nurses, namely, hospitals? Not only this, but the current radio campaign of recruitment of nurses advises young people to go to the nearest *hospital* if they are interested in education for nursing. We do not send law recruits to the nearest courthouse or prospective teachers to the nearest public school.

In spite of the fact that Florence Nightingale's spirit is invoked so frequently by those who oppose the improvement of nursing education, we have not yet been able to carry out Florence Nightingale's plan for a school. It is from the founding of her school in 1860 that we date the modern period of nursing. She had at her disposal about 60,000 pounds with which to establish a school of nursing, aside from the need to supply nursing to the hospital. The criterion of an independent school was not part of the development of nursing schools in this country, for in order to get into the hospital situation, students were required to do all the work—scrubbing and cleaning as well as nursing. The rapid increase in numbers indicates that nursing schools quickly became an economic asset to the hospitals. Even today, nearly 80 years since the first three schools of nursing patterned after the Nightingale system were founded, we find that in the schools owned and operated by hospitals 80 per cent of the nursing care is given by students.

A comparable situation in education would be the following. Let us suppose that because teachers are needed (and they seem to be) a ten-room elementary school opened a teacher-training program. Not only would it operate such a program but, in the process, eight of the ten rooms would be staffed by students learning to be teachers. Surely no one would endorse this in teacher education but the public seems curiously unaware that this is the method by which most students learn nursing. Or let us suppose that 50 per cent of the teacher-training institutions were staffed by instructors who had graduated from high school, 25 per cent having had one course toward a bachelor's degree and 25 per cent holding at least a bachelor's degree. This is the present situation in education in nursing.

Still another paradox relates to the standardization of education. Early in this century, when nursing education was in its infancy, efforts were made to secure laws for the licensing of nurses and the development of comparable educational standards. The

early leaders talked at great length about the benefits that would come to nursing in the solution of educational problems as soon as education was standardized. This standardization was accomplished in 1917, when a Standard Curriculum for Schools of Nursing was published. This curriculum was revised in 1927 and 1937. Ironically, standardization is now one of the chief blocks to developing an education suitable for the times, for the specific standards and requirements permit little flexibility in adapting education to fit present needs. Furthermore, although as was mentioned earlier the human relations element is so important today, particularly in psychosomatic medicine, we continue to prepare the majority of nurses by teaching them manual skills only. The assumption seems to be that the students will bring with them, made to order, the skills in interpersonal relations by being sympathetic and understanding. These qualities are important but they are not enough for understanding and dealing with the psychological and sociological needs of people today.

In the financing of nursing education we discover a paradox. An accepted educational principle is that students are not expected to pay the entire cost of their education. The average paid by students in college is about 40 per cent, with variations in individual institutions. Nursing students pay not a very large proportion of the cost of their education in cash but a great deal in services which they render to hospitals. In a study made by the United States Public Health Service it was found that in the group of schools studied, the nursing students paid not just 100 per cent of their education but 111 per cent! If this is translated into actual cash value, nursing students in the average school contribute thousands of dollars worth of services annually. No nursing student can pay her way in securing an education. She is obligated by hospital needs and state regulations to work her way through. Furthermore, the ratio of hours of education to service is about one to eight. If the hospital experience were to be considered as laboratory work, which is what it is, this ratio should be more comparable to what is customary in educational institutions.

It is paradoxical that while colleges and universities permit students to carry only 16 to 18 hours of instruction per week, the nursing student works an average of 44 to 48 hours weekly. The bulk of the instruction is usually crowded into the first six months in order to permit longer working periods later in the course. It should be kept in mind that during this time the students are supposed to be learners. The strange part of the situation is that nurses themselves are loath to change this system, and the public is uninformed or accepts this as being the way we must of necessity learn nursing.

It is regrettable that only 10 per cent of nursing schools are located in colleges and universities. These institutions seem not too deeply interested in developing programs in nursing education, despite the fact that the first college recognizing the need and organizing a nursing school did so in 1909.

It is curious that while the environment in which the nurse learns has gone ahead so rapidly in facilities, medical discoveries, new apparatus, new drugs, and so forth, and other types of education have progressed, education for nursing has been caught in some backwash and has not gone along with progress in related fields.

We have been remiss in not pointing out these shortcomings to the public and asking for its assistance. Nurses wish to share these problems with educators now, believing that educators can help develop a demand for a new, fair deal in education for nursing. Those who are in a position to advise young people should understand the type of education given in hospital schools and in collegiate schools, and encourage them to choose truly educational programs. Those who are in institutions of higher education, junior and senior colleges and universities, should interest themselves in helping develop educational nursing programs comparable to other college programs

which permit students to share in the general college life and benefit from a preparation which permits educational needs to be fulfilled.

Now to avoid leaving the impression that the paradoxes in nursing are all unfavorable or negative, mention will be made of some that reverse the picture. It is always of interest to nurses to see other educational fields seek so eagerly for real situations in which students may have learning experiences that will be beyond the classroom and deal with live materials. In nursing we have always had this, for the hospital, with all its human problems, has traditionally been the laboratory for learning. Our problem has not been to provide live materials but to prevent the real situation from crowding out the student's opportunity to absorb, use, and interpret the vast amount of material available. We believe, with Dr. Elliott Dunlap Smith, that students should be given only as much field experience as we can "prepare them for and help them recover from." Also in our favor is the fact that nursing is one of the few professions, excepting teaching, that has recognized the need for the preparation of its teachers and administrators. In medicine, law, and other professions, the person who can practise successfully is assumed to be capable of teaching what he practises. Not only has nursing recognized that preparation for teaching is in reality the adding of another profession to that of nursing but such preparation has been going on in nursing since 1899. It was in that year that Dean James Russell admitted into the Teachers College family, graduate nurses who intended to prepare as teachers and administrators. For this reason the Division of Nursing Education exists in the College today and graduate nurses sit in classes with students in general education.

In retrospect, what is the meaning of these paradoxes and what is to be done about them? They are in reality the incentive behind the nursing profession today, as it plans and works for better education and better practice to meet society's health needs. Were there no paradoxes, nursing and nursing education might become static, and a profession which is static has lost its *raison d'être.*

Something He Ate

Food has its effect not only upon the individual's health but also upon his temper and his mental outlook. Upset digestion or a meal that didn't agree with him doesn't make for a pleasant day for infant or adult. Many of those in their senior years would feel a great deal better if their diet were more wisely planned. An older person may be poorly nourished, not through lack of food but through dietary deficiency while eating too much of the wrong kind of food. Through dental troubles, he may be unable to eat the proteins he needs, in such sources as meats. By putting harder foods through the meat chopper, the fibres are broken up and less chewing is necessary. Fruit, vegetables, milk and milk products should all be on the older person's menu.

When we consider what now constitutes good nursing care, it is true that the emphasis is changing as more and more we speak of the preventive aspects of disease, of the need to study the social background of our patients, and of nursing as a community service, not confined within the hospital walls.

We are sometimes apt to think that, in a scientific age, technical efficiency is of most account in our education of nurses and in the service they give. But our patients are human beings, requiring not only our skill but also our sympathy and our understanding. —DAISY C. BRIDGES

Executive Secretary, I.C.N.

I Was a Nurse

KATE WATSON

(Continued from the May issue)

Part II

AS INTIMATED PREVIOUSLY, my new world took me into private duty nursing, since a short term at institutional work indicated that it was not adjustable to caring for certain family conditions in my own home. Also I liked the actual nursing of the patient, whether in the hospital or private home. In those days practically all home nursing was on a 24-hour basis. Hospital nursing for 12 hours, either day or night, paid $5.00 a day. Twenty-four-hour duty in homes was $6.00, with a possible four hours off duty. Since the very sick were practically the only ones who utilized the services of a nurse, under ordinary circumstances, it was frequently inevitable that a nurse's rest would be disturbed several times a night.

It was common practice for a nurse to carry such articles as a hot water bottle, enema outfit, small kidney basin, dressing basin, forceps, hypodermic syringe, drinking tube, and the ordinary necessities which today are found in most homes, but with which few homes were equipped at that time. One quickly discovered where the electric switches were located and where the right dishes were to be found. While respecting the fact that most people tried to conserve on electricity, I nevertheless formed the habit of leaving on the bathroom light, at least until I was completely familiar with the home.

I had a very interesting experience in one home one night. It was in quite an exclusive district with many shrubs and trees. The windows of the home were unscreened and, it being summer, were open. About 2:00 a.m. my patient's hypodermic was due and I went into the bathroom to prepare it for her. For a moment I stood transfixed. The walls of the lighted bathroom were literally covered with well over a hundred butterflies and moths that had been attracted to the light from out of the night. They were large and small and of many unusual varieties. I was fascinated by the beauty of them, even while filled with apprehension as to how I could get them all out. I visualized myself swinging a bath towel and being the centre of a cloud of moths! Then as quickly I realized that if the lights were put out, they would silently flutter away.

I remember at one time reading that in some parts of Ireland, butterflies are referred to as flutter-bys. It seems a more descriptive term than our English interpretation. On this occasion they justified that name. I wanted to tell my patient next morning of the interesting phenomenon, but I did not feel I knew her well enough to judge her reaction to this nocturnal invasion of her prettily decorated bathroom.

In the early fall I went home to see my father and a younger sister who was keeping things homelike for him. It was a treat to get home. The brief vacations in training had been tantalizingly short. It was at this time that another sister was expecting a baby. Since she was living in a town without hospital facilities anyway, I suggested that she come home for her confinement and that we make the occasion a visit together. She agreed, so I most carefully prepared and sterilized laparotomy stockings and towels. I wanted to impress the local doctor with my fine training!

With the early pains I called him and after visiting the prospective mother he went on an urgent trip to the country, assuring me that he would be back in due time. I set about boiling water and sterilizing basins in the freshly scrubbed clothes-boiler, meanwhile keeping an eye on the patient. I suppose that the doctor's air of nonchalance was in some measure communicated to me because I just ac-

Toronto General Hospital uniforms in 1881

cepted the fact that he would be back in good time for the delivery. Neither of us, of course, expected that the case would enter the final stage so quickly. He walked into the room just as the baby was born. I think I have never before or since been so excited. Although I had assisted at many births while in training, I had never delivered a patient alone — and this was my sister! I almost forgot to put on the famous laparotomy stockings! Never since have I had a similar experience. It was one I shall not forget.

There was little sickness around the countryside at that time but when I returned for the Christmas holiday season, it was quite impossible to refuse the doctor's appeal for nursing assistance. There was no nurse in the town. Fortunately in those days when there was sickness, the term "neighbor" reached its full stature. Winters were rather severe and it was quite common for the snow to drift over the fences. Sometimes when the crust was hard, I have known the doctor to drive across the field in his cutter and horse, rather than go by the drifted side roads.

We drove across the frozen lake on several occasions. I believe a depth of 18 inches of ice is considered safe for such travel. I wasn't filled with too much assurance but on only one trip was I actually fearful. The spring thaw was setting in and the water was seeping in places over the ice. On the whole I preferred terra firma, even though I had to take "pitch holes" into the bargain.

With the modern fine roads and snow ploughs, pitch holes are probably unknown to most of the present generation of young people. On one call in the country, after several weeks of strong winds and heavy drifting snowfalls, we counted 129 pitch holes in the first mile and a quarter of our trip, along an especially bad stretch of road. An old nag would probably amble gently up and down over the humps. I knew from experience, because many times in my young days I had hung on bobsleighs. It was fun. But the doctor's mare didn't believe in such slow methods. She had some racing blood in her veins. Moreover, she disliked the pitch holes intensely and preferred to jump them all. The cutter

stood the test and so did we, all bundled up as we were in buffalo robes. More than once, however, the cutter was suspended for a breathless moment on the edge of a snowdrift or an extra big pitch hole. The patients liked the doctor's mare. She got him there in the minimum of time, which was long enough if the roads were bad, or if the patient was suffering and watching the clock for his arrival.

The Christmas visit home, the following year, 1918, was an unforgettable one. The flu epidemic had started and already a nameless dread possessed the people all over the countryside. The first casualty in the vicinity, after only three days, was a strapping young fellow. People couldn't credit it. It was terrifying. But that was how that particularly virulent and insidious flu epidemic reacted. People thought they were contracting a cold and in a matter of hours they had developed pneumonia. I knew right away that there was no returning to the city until I had shared the anxiety and done my part in seeing this thing through.

The telephone rang — it was the doctor. Would I be ready in a few minutes to go to a home seven miles away in the country? Seven miles seems so trivial in this age of mechanized travel but it was a long drive by horse, under rather severe winter conditions. We found the whole household excepting the father down with flu. The home was the typical small, two-storey farmhouse of that day, with few of the conveniences as we now understand them. In a small bedroom off the kitchen was the mother, a woman of about 50, obviously with the restricted breathing and sharp pains of pleurisy. In another small downstairs room was a teen-age lad, critically ill with pneumonia, and in the two small bedrooms upstairs was a grown-up daughter and another son. How I wished that I could at least have had them all on one floor but the facilities were meagre and the patients too sick to be moved.

After giving all the sick ones a careful chest examination, the doctor made up big bottles of medicine from his well-stocked satchel. He then left, with orders to give regular doses of this every four hours to each patient, as well as to apply mustard plasters and linseed poultices to the chest — back and front. How little we dreamed of a time when all these treatments would be antiquated because of the wonder drugs of science! Because of them, life has become incredibly simplified for patient and nurse.

For once the neighbors, the nearest of whom was a quarter of a mile away, failed to come to the rescue. Everyone was terribly afraid of contracting the flu. The man of the house had to care for the animals, milk the cows and do the chores, with which normally the boys would have assisted him. I somehow managed to prepare the most simple meals, specializing in broths and light custards, for the sick. They were critically ill and I felt the necessity of making constant rounds even in the night, as well as administering and removing the plasters. The doctor had so many sick people to visit that he left it to me to report progress by telephone. That was one way the whole countryside learned how things were progressing. On the morning of the seventh day, I could see visible improvement in my patients and I had to admit the absolute necessity of getting rest myself. The doctor made his first official call of the week and was very gratified with results. In the interval he had travelled many cold miles. He warned the patients to still be careful and to keep warm and away from draughts. Leaving everything in as good condition as possible, I took the opportunity of returning with him.

In two or three days I again accompanied the doctor to another critical case of pneumonia. There were only two people in the home, a tall lanky Scot and my patient — his only daughter, who closely resembled her father in stature and appearance. Since her bedroom was a small room off the kitchen, I got what rest I could on the kitchen sofa. The father slept in a practically unheated room upstairs. Most farmhouses had a large kitchen and in many cases it was the only well heated and thoroughly used

room in the house. With a big stove and a well filled wood box, it was a comfortable, even if humble room.

The question of bathing was always a problem with me on such cases, especially in winter. I decided that two o'clock in the morning, when I got up to give medicines and put on a poultice, would be a good time for bathing operations. It was at least private and, in any case, I couldn't take the risk of falling asleep while the plaster was still on the patient. It worked very well to put the basin on the kitchen chair beside the stove, which had been freshly replenished with wood. In those days most people in the country places had their Saturday evening bath in the washtub before the fire anyway. It was quite possible, too, unless one was in the six-foot, 250-pound category.

The goodhearted Scotsman was very grateful to me for the care of his daughter and, in his kindly way, was concerned that I should get proper nourishment. He had one duck laying at the time, as well as the hens. He insisted that I should have the duck egg for my breakfast every morning because it was larger. I wondered if it would be an uncertain privilege, as duck eggs are sometimes strong in their flavor. Fortunately, the duck was grain-fed, so it was as delicate as a hen's egg. I learned to value the kindly hearts of the country people.

(To be continued in the July issue)

More Vitamins

SYRETHA MILLEY

THE FARM BUREAU members had just finished what they termed a "square meal for health." The meeting place was a farm house remodelled in accordance with suggestions made by the Extension Service of the University of Maine. The Home Demonstration agent (hereinafter known as the H.D.A.) — she always holds a degree from some university in home economics — was to address the group. She had hardly taken her place when the foods leader, who up till then had been adding up her score card, said jokingly, "Ain't enough vitamin C here." The meal had seemed more than adequate. Indeed it led me to think that "square meals" tend to make one round but the tomato juice had been forgotten. It was now passed and we solemnly drank our vitamin C.

This Farm Bureau is part of an Extension Service of the University of Maine. The Dean of Agriculture heads all the activities. Under him are three organizations: The College of Agriculture, Experimental Station, and the Agricultural Extension Service. The personnel includes administrative leaders, specialists in various fields, and a full corps of County Club agents and H.D.A.'s to serve the counties in which they are located. Broadly speaking it has a threefold program — agriculture for men, home economics for women, and agriculture and home economics for boys and girls through the 4-H clubs. I can testify to the excellent bread made by 4-H boys. On the other hand, I watched a frail girl of ten expertly use both plane and saw in making a flower table.

I came upon this extension service while taking a course in home economics at the university. I was completely fascinated by it. When classes were out I lost no time in getting to know the different specialists and H.D.A.'s visiting the districts with them.

The people of Maine are often called "Mainiacs," to distinguish them from, say, "Vermonters." It did seem like madness when I asked the H.D.A. to take me on a tour, expecting her to say as we do at home in Canada "a week from Tuesday," to have her reply, "Delighted! Meet me at the

Mrs. Milley, who was an active public health nurse prior to her marriage, resides at Yarmouth Centre, St. Thomas, Ontario.

Court House tomorrow morning at 6:30." That was a very reasonable suggestion for her office is in the Court House. She has to drive 140 miles to the meeting so an early start is necessary. If a *salad* meeting is planned she will pick up her vegetables at the last town — something to do with loss of vitamin C. Arriving at her destination, she meets the local bureau leaders, who conduct subject matter meetings and demonstrations for the local group in foods, clothing, and home management.

For animation, interest, and follow-up there is nothing to equal this Farm Bureau. One immediately realizes the value it must be to the public health nurse, for instance, in the matter of school lunches. While the school authorities are, of course, responsible either directly or through some local agency for supervising and serving community school lunches, the local foods leader will often go into the school to demonstrate the "good" and "bad" lunch. Using cellophane wrapped items so that all may see, she will discuss what should go into box school lunches. In one area 91 of these demonstrations were given before 3,417 students in one year while 53 meetings on the same topic were held with parents. Thus much valuable teaching goes into the homes. What a joy it must be for a public health nurse to have such cooperation and interest displayed in the family's welfare!

But to get back to our meeting. The H.D.A. spoke simply in the following manner:

> Women — During the past five years, tests have been made on you and some of your children to show us the foods we need to eat to get the most out of life. This study has included blood tests for hemoglobin, vitamins A and C, and carotene on 185 adults from all counties in Maine and on 780 junior high school students. The study has also included physical examination by physicians and diet studies on the junior high school students.
>
> *Results of the blood tests for adults indicated:*
>
> 49% of both men and women below normal in carotene.
>
> 48% of the men and 35% of the women below normal in vitamin C.
>
> 10% of the men and 9% of the women were low in vitamin A.
>
> 10% of the men and 20% of the women were below normal in hemoglobin.
>
> *Results of the blood tests for students indicated:*
>
> 85% of both boys and girls below normal in carotene.
>
> 69% of the boys and 48% of the girls below normal in vitamin C.
>
> 40% of both boys and girls below normal in hemoglobin.
>
> 40% of both boys and girls below normal in vitamin A.
>
> *Results of the study* indicated that the junior high school students in all areas showed similar types of nutritional defects. These included: underweight; signs of previous rickets; rough, dry, "goose pimply" skin (probably related to deficiencies in vitamin C and A and carotene); red, peeling lips; cracks and sores at the corners of the mouth (related to a deficiency of the B vitamins, especially riboflavin); changes in the surfaces of the tongue (probably caused by a deficiency of some of the B vitamins); inflamed gums (in most cases associated with a deficiency of vitamin C); and decay of the teeth. Reddened, peeling lips and inflamed gums were seen more often in the boys than in the girls.
>
> What do these tests and studies mean to those of us responsible for the health of our families? First let us find out what the words used mean and in what foods they can be found.
>
> Vitamin A is a fat-soluble vitamin formed from carotene. It is necessary for growth, feeds the eyes, skin, nerves, teeth, bones, and helps ward off infection. Carotene is the deep yellow pigment found in butter, cream, leafy green and yellow fruits and vegetables. As we eat these, the body uses them and changes them into vitamin A.

Here the H.D.A. gave a list of foods rich in different vitamins, to help correct the aforesaid deficiencies, bringing these scientific findings down to our working level, for she said:

> Modern living demands that we follow scientific findings, if we are to survive. Did you ever stop to think why some

days stand out as banner ones? Everything goes along smoothly and meals are prepared, served, and eaten especially well. Everybody likes and eats with relish everything offered. When you analyze one of those days, you sometimes find that you had *planned* that day's meals. The food, while good, wasn't too fancy. Yet you managed to satisfy all the various members of the family. How can we do this more often? By planning three meals together, that fit to make a perfect whole to meet body needs. Once the habit is established, it doesn't take too much effort to keep it up.

How can we start? What we eat must fit:

1. Our *pocketbooks.*
2. Our *climate,* because we like different foods that go with different seasons of the year.
3. Our *work,* because those of us who do hard work need much more food than those who sit all or most of the day.
4. Our *age* and our *sex* because different ages require different amounts of food. Men usually require more food than women. Children need as much and teen-agers more than their parents.
5. Our homes and *modes of living,* because while some of us have plenty of time for cooking for our families, others have little if any time.

She then took our old, everyday meal patterns and drafted basic menus. She told us of the research being done on *breakfasts* — about women who ate breakfasts ranging from an unsweetened cup of black coffee to one that was really a basic meal. The latter reported that a high-protein breakfast was more satisfying for a longer period of time and they felt better too; those drinking the unsweetened cup of black coffee reported feelings of hunger, weakness, headaches and lassitude. Work done at the University of Nebraska on college girls showed that including some protein for breakfast, dinner, and supper was of more value than including the same amount of protein for only one or two meals. Most of us can say that we have felt the same way when we have skipped or eaten poor meals, in contrast to the times when we have had a well balanced meal.

What do we need? Protein, vitamin C, vitamin A, B vitamins, calcium, iron, calories. With this broad range of requirements, the question — what is a basic pattern for any meal? — can be answered in many ways. In menu-making remember:

Select the main dish. Build the rest of the meal around it. Use vegetables, fruits, salads, with color, flavors and textures to go along with the main dish. Watch the dressing on the salad. Choose soup and bread to go along with the rest of the meal. Desserts can often make or break a menu. Beverages should be chosen with care. The meal should be satisfying but nutritious.

The talk was ended but questions came thick and fast. I picked a few at random as I listened:

How can we plan our meals when our family has a two-year-old at one end, a 70-year-old grandfather at the other, with different ages between? We love them all and we want to have them ready to eat at the first call; not lag behind and have to be coaxed to eat something different. What are the foods we can cook for a toddler and an aging person? What are the foods that build muscles and keep them in repair?

I came away from that group, feeling that the H.D.A., or "Home Demmie" as she is known locally, was "prophet, priest and king" in her county for she knew all the answers. I thought of the University of Maine, not as a seat of learning, but as a giant filling station with pipe lines leading into all the big and little communities of Maine, pouring knowledge into the homes. This year alone 2,000 women will be trained.

More than 8,000 peace treaties have been signed in 3,434 years of recorded history. During this time there have been only about 268 years of peace.—HAVELOCK ELLIS, in *Study of British Genius.*

The drug N-allylmorphine has proved to be of value in counteracting the harmful effects to the fetus of morphine or other analgesics given the mother. This may have considerable importance in human obstetrics.

The A.B.C. of Vitamins

A

Oh! fine and fat was Ralph the Rat,
And his eye was a clear, cold grey,
How mournful that he ate less fat
As day succeeded day;
Till he found each cornea daily hornier
Lacking its Vitamin A.
"I missed my Vitamin A, my dears"
That rat was heard to say;
"And you'll find your eyes will keratinize
If you miss your Vitamin A."

B

Now polished rice is extremely nice
At a highly suburban tea.
But Arbuthnot Lane remarks with pain
That it lacks all Vitamin B.
And beriberi is very, very
Hard on the nerves, says he.
"Oh, take your Vitamin B, my dears,"
I heard that surgeon say;
"If I hadn't been fed on Standard bread,
I shouldn't be here today."

C

The scurvy flew through the schooner's crew,
As they sailed on the Arctic Sea;
They were far from land and their food was canned,
So they got no Vitamin C.
For "Devil's the use of orange juice,"
The skipper had said, said he;
They were daily fed with pickled pork,
Those mariners bold and free.
Yet life's but brief, on the best corned beef
If you don't get Vitamin C.

D.

The epiphyses of Jemima's knees
Were a truly appalling sight;
For rickets strikes whom it jolly well likes,
If the Vitamin D's not right.
Though its plots we foil with our cod liver oil
Or our ultraviolet light.
So swallow your cod liver oil, my dears,
And bonny big babes you'll be;
Though it makes you sick,
You mustn't stick,
For its teeming with Vitamin D.

E

Now Vitamin D and A, B, C,
Will ensure that you're happy and strong;
But that's no use, you must reproduce
Or the Race won't last for long.
So Vitamin E is the stuff for me,
And its praises end my song.
We'll double the birth rate yet, my dears
If we all eat Vitamin E;
We can blast the hopes of Marie Stopes
By taking it with our tea.

—*The Nursing Journal of India*, March, 1953.

Practical Help Given

Out of every thousand babies born throughout the countries of South East Asia, from 150 to 350 die in their first year of life. Mortality among mothers is also too high. Apart from humanitarian values, this represents a serious economic loss of life capital.

No international expert is needed to point out the reasons for this — the malpractices of untrained village midwives, the unsanitary conditions in town and village, the menace from impure water and flies and, most serious of all, the ignorance of mothers of how to feed and care for their children. Where the practical assistance of WHO doctors and nurses is of value, however, is in helping governments to organize the multitude of mother and child health centres needed, and to train the children's doctors, public health nurses, midwives, home visitors, and sanitary inspectors required to staff them.

Already, with assistance from UNICEF and WHO, maternal and child health centres and practical training schemes are operating successfully in Afghanistan, Burma, Thailand and elsewhere in South East Asia. Several new centres are planned to open in 1953.

—*WHO Newsletter*, Mar. 1953.

He is a happy man who has simplified his tastes to the point where a good book and a free and quiet evening are for him, not a chore, or a sign of increasing age, but a preference and a badge of wisdom and distinction.—Sir Joshua Stamp.

Supervision — Estimating the Supervisor

MARGARET MCINTOSH, B.SC.

IN LAST MONTH'S article we discussed the person receiving supervision. Now let us turn to the person who is the supervisor. Let us begin by the statement that an efficient happy staff is one that is secure in the knowledge that theirs is a leader prepared emotionally as well as technically for her position. In her presence one is aware of an atmosphere of comfort and ease. The dominant factor responsible for this environment is the supervisor's conscious effort to be fair in every situation. There is no room for the human weaknesses of favoritism and prejudice. Being just, the supervisor does not write a report of an individual without a great deal of thoughtful consideration. A promise is made only when it is certain to be kept; furthermore a means is found whereby the promise will be remembered and fulfilled.

There is another quality that proves invaluable to the successful leader. It is the ability to be considerate of the feelings of those whom she directs. She remembers that it is with small actions that we please people.

This matter of being considerate has, as a basic point, the habit of always acknowledging the presence of other people. This awareness of another does not necessitate a spoken word. In many cases where an encounter is repeated frequently a glance, a smile or a nod is quite sufficient. It is a normal human need to wish to be recognized. The sensation of being slighted is very often the beginning of a serious misunderstanding.

The first encounter may be that of a pleasant "good morning" or "good afternoon" as the case may be. However, should the occasion warrant a more formal greeting, the tone of voice and manner of the supervisor will show that the situation requires an approach of a more serious nature. For the staff member, the most annoying and, later, the most intolerable characteristic is found in the supervisor who smiles too much and whose words are sweet to the point of being insincere. The staff nurse prefers to be received in a polite and interested manner. An opportunity for smiles and pleasantries will appear once the point of discussion has been cleared and, at this time, they will be more readily accepted as sincere.

There is another outstanding trait in the personality of a person who is successful and happy in her chosen field. This is the development of a sincere interest in her work and in the people who work with her. This interest, that is very apparent, has as its foundation certain forms of behavior that eventually become habits:

1. The development of the faculty of remembering people's names and certain facts associated with them. Once the name is at hand, use it directly and frequently during conversation.

2. Contriving to have a sincere and genuine interest in topics being discussed by others. This, understandingly, necessitates a reasonably broad background of general information.

3. Conducting interviews and conferences with the least possible outside

Miss McIntosh is a member of the staff of the Montreal Department of Health.

interference. If an interruption occurs as a result of office routine or of personal preoccupation, it would be more beneficial to both the nurse and the supervisor to make plans for further discussion at a later date. Preoccupation is readily observed and a feeling that there is little room for or likelihood of constructive thought soon develops.

There is another outstanding feature in the personality of a supervisor who is appreciated by her staff. This is the ability to be tactful and diplomatic in her approach to an individual or a group. Such a supervisor never makes unnecessary or outright demands of her nurses. Her approach is in the form of a question such as "Would you mind?" "Do you think you might be able to do this?" or "Do you think that if you do the job this way you might find your work less difficult?" The staff soon learns that a request is made or advice is given only when absolutely necessary for the welfare of the nurse and of the organization. The reaction to such requests is cooperation rather than insubordination.

There is one factor in this ideal picture that must not be overlooked. Cooperation does not always result in action without question. There is, rather, in this atmosphere an understanding on the part of the nurse that the supervisor will listen to a discussion of the subject and that the door is always open for constructive criticism.

The leader who does not give the impression of being entirely materialistic may ask anything within reason from those who follow her. The supervisor, in other words, may show that she is interested not only in the amount and quality of work that a nurse can accomplish, but also she acknowledges that there is a place for interest on the part of the staff in topics outside the nursing field. Their attempts to broaden their viewpoint in other directions should be encouraged at all times.

The supervisor may show not only an interest in the professional but also in the personal qualifications of her staff members. There is a need in every member of the staff for this kind of attention and it will differ according to the personality of each nurse. The one, however, who particularly needs consideration is the person who is completely alone because of a lack of immediate relatives or as a result of a peculiarity in her own behavior. There may be an opportune moment when help may be given to this person However, it requires a great deal of understanding tact and experience to be able to act at the right moment.

The supervisor may feel hampered in her efforts to reach this person because of past personal contacts or because of a lack of experience in this type of situation. It is at this moment that a courageous and mature person will turn to a more qualified person for advice. The supervisor need not fear that the staff, should this fact be made known, will feel that she is not capable of sound leadership. They will, rather, appreciate her all the more for this demonstration of being, as all humans are, not quite perfect.

Aside from moments of personal stress, there are times when we all feel a need to be within the circle. In order to create this warm atmosphere of belonging, remarks regarding family activities that occur in the average life of all individuals are quite beneficial. In this almost idyllic situation there is usually a person who takes into the circle only her professional life and respect should be held for her desire for personal privacy.

There is the supervisor who seems to have the situation in hand at all times. She is usually a pleasant and agreeable person. This impression stems from the fact that she is able to say "No" in a tactful yet an impersonal manner. She shows that the refusal is based on a regulation of the organization and that if it were possible she would, understanding the need, allow the request to be granted. There is never a moment when the person making the request is allowed to feel that it is Miss —— who is saying "No." In situations where this feeling does exist, the nurse soon believes that "Miss —— does not like me" or "If I were Miss —— this kind of request would be granted." This opinion results when a supervisor has

allowed her personal opinion to replace the rules of the organization.

An ideal supervisor does not attempt to force her superior fund of knowledge upon the members of her staff. A person who is never appreciated is the one who is too ready to give the answers. The best policy would be to wait and allow an individual who has more need of the focus of attention to give the information. The staff nurse who is requesting aid is ready to receive it. Then help may be given when it will be most useful. The staff unconsciously accepts the fact that the supervisor has a superior background. There is always a reason for the failure on the part of the staff to request help and direction from their leader. The conscientious supervisor soon observes this and in time finds the cause and looks for the remedy.

The last but not the least important quality that a supervisor should have is the ability to control her own emotions. One understands that it is difficult to restrain feelings of pleasure or displeasure towards an individual or a group. This habit once formed is priceless but it is the result, in many cases, of years of practice and effort.

The person who waits minutes and days before commenting on a situation is the person who has given the subject a great deal of thought and study before giving her opinion. In this manner, conflicts that arise from remarks made in haste are often avoided. The injuries caused by such behavior very often can never be repaired. The sad part of this story is that, in a majority of cases, the person who causes the injury is not aware of the results of her thoughtless behavior. The main point to remember is that a person who tries to avoid hurting others is considered kind and will, as a result, be regarded by her co-workers with love and respect.

In closing, may I say it has been possible, with so large a topic, to cover only the outstanding points that have presented themselves to me. I have drawn not only from the contacts made within the organization where I am presently employed but also from experiences in my school life, my training for nursing, my post-graduate studies, and from the observation of the persons with whom I have up to this time worked.

I have come to appreciate the fact that the individual who is responsible for supervision does not necessarily need to be a complete picture of perfection. She is a person who, aside from her professional responsibilities, is still able to live her life as a human being, and a woman.

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Walking Tall

Good posture is important to children and adults. As youngsters grow, they should be taught to walk and stand without shuffling or slumping. Dropped head, round shoulders and back, flat chest and protruding abdomen in adults may be the result of faulty posture when young. This is more easily prevented than corrected. Children should be given plenty of outdoor exercise but not allowed to become fatigued from overactivity. They should be trained to sit erect when reading or studying. While sleeping, a child's bedcoverings should be light but warm, not heavy enough to restrict movement and stretching.

Sanitary Regulations

On October 1, 1952, new International Sanitary Regulations drawn up by WHO became effective in all WHO member states which did not give formal notification of their objection or reservation. These regulations, superseding outdated conventions, seek to interfere as little as possible with world travel and trade while giving maximum protection against the spread of disease.

Nursing Team Organization

CLARA E. PERRY

AFTER LISTENING to several discussions and attending hospital nursing team demonstrations, we began to wonder if it might not be a good thing to start it on our floor — for of course we wanted the best for our patients and our students. How to start with what we considered an inadequate nursing staff was the big problem. So we made an analysis of our objectives, needs, and resources.

The clinical department consists of ten four-bed rooms and five two-bed rooms, thus accommodating 50 patients in varying degrees of helplessness.

Reviewing what we had heard and seen regarding nursing teamwork, we made our plan. We had been told that 20 patients was an ideal number for a team to care for. Our ward was an awkward number to divide: three teams would be too difficult, so we planned for two teams with the following staff:

1 Supervisor.
1 Head nurse.
1 Clinical instructor.
2 Team leaders (R.N.).
8 Student nurses.
5 Nursing assistants (one as replacer).
(Please see: Nursing Team Organization chart).

FUNCTIONS

The head nurse assigns the patients to the teams each Monday morning. The team leader assigns daily duties in such a way that each nurse has an opportunity to nurse all patients under the team's care, for a definite period of time.

It is very important to have a good team leader, one who can assess readily the needs of the patients and, equally, of the students in nursing education. Each week the students are switched to the opposite team to assure everyone of a "fair share of experience."

The duties are assigned to each student according to her previous experience and her ability. The team leader cares for the patients needing greater nursing skill, giving over-all supervision at all times, seeing that no time is wasted and that those who have finished an allotted task help those with unfinished work. So that it may truly be called teamwork, "no one is through until all the members of the team have finished." Usually around 9:30 a.m. the general nursing care is given and by 10:00 a.m. medications have been dispensed.

Each team has a bulletin board on which are posted assignments for one week. Special duties are also indicated:

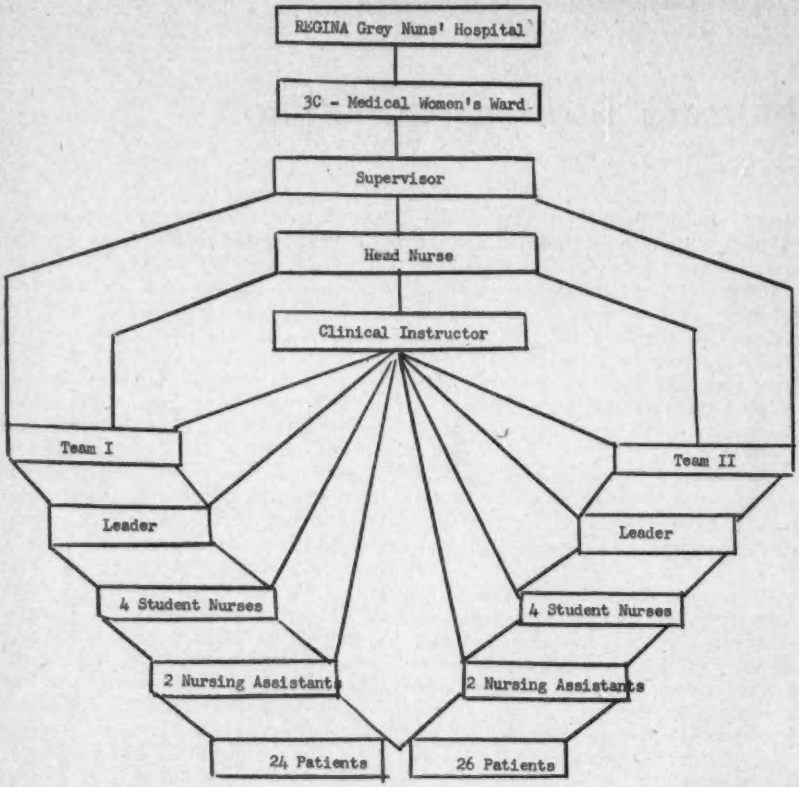
Administration of penicillin at 10:00 a.m. and 1:00 p.m.
Temperature: 10:00 a.m. and 2:00 p.m.
Lunches: 10:00 a.m. and 2:00 p.m.

A nurse is assigned to administer medications and treatments to the patients (chronic or minor illnesses) who are being cared for by the nursing assistants. Each nurse is responsible for the charting regarding the patients under her care. If a nurse is off duty from 1:00 to 4:00 p.m., her afternoon duties are assigned to another member of her team.

A daily conference is held for each team, conducted by the team leader. Team I meets at 10:30 a.m. and Team II during the patients' rest period at 1:00 p.m. At these conferences, the supervisor, the head nurse, and the clinical instructor are welcomed in order that they may be kept informed of the patients' conditions, nursing

Mrs. Perry is head nurse on 3C — women's medical ward, at the Regina (Sask.) Grey Nuns' Hospital.

NURSING TEAM ORGANIZATION



problems, etc. Each member brings a contribution to the conference in reporting. The discussions are helpful since guidance can be given as problems arise. Students recognize that their experience is more educational and everyone has a feeling of being an important part of a working unit.

WE ALL LIKE THIS TEAMWORK!

Leaders like it because, having more administrative responsibility, it means more experience and work is consequently more satisfying.

Student nurses like it because they get to know all the patients and hence, on occasion, can make rounds with doctors with a feeling of competence and security.

Nursing assistants like it because it is more interesting. They enjoy the conferences, learn more about the patients, and have the feeling of being part of the team.

Supervisors and *head nurses* like it because they feel a higher standard of service is being rendered.

Clinical instructors like it because the students seem to be stimulated and more eager to learn since they are requested to report on their observations at the team conference.

Our adaptation of this plan is by no means perfect but, with the practice and knowledge gained, we feel that even when we have to work with fewer personnel, it will be possible to attain our objectives: Better service to patients, more help to student nurses, and a higher standard of efficiency.

Trends in Nursing

On the Slate at National Office

WE ARE SURE that our members sometimes wonder just how National Office fits into the nursing picture. These members frequently confer with the executive secretaries of the provincial associations but, except at the time of Biennial meetings, do not hear a great deal about the C.N.A. staff.

Projects now under way keep the general secretary or the assistant secretary out of the office a considerable portion of the time. Working parties of the Committee on Health Insurance and the Educational Policy Sub-Committee to study the Preparation of Professional and Auxiliary Psychiatric Nursing Personnel each took three full days recently. The preparation of the final reports and recommendations, and their distribution involved more time. In order to prevent the shelving of these valuable pieces of work, many formal and informal contacts had to be made and interviews arranged.

Recently the status of immigrant nurses has been receiving considerable attention. The National Employment Service officials have been in National Office conferring with us about procedure in relation to the recruitment of nurses from Europe. Although we are all very familiar with the implications of the B.N.A. Act and its effect on federal-provincial jurisdiction in matters of health, it is very difficult to explain this to non-Canadians. As a result, some immigrant nurses have been arriving in Canada and finding themselves ineligible for registration in the provinces. It is to remedy this as well as to control recruiting that the C.N.A. has been asked to give assistance.

Aside from all these activities, the postman calls twice a day bringing inquiries, requests, and reports from all quarters. As the provincial executive secretaries know, a lively correspondence is kept up between their associations and National Office. The I.C.N. and member national associations request our assistance in arranging itineraries for visitors and in turn plan interesting tours or employment for our members going abroad. Nurses hoping to immigrate to Canada write for information concerning registration and licensing as well as employment opportunities. Sometimes it takes a great deal of digging to answer some of their questions. For instance: "As I plan on bringing my aged mother with me, would it be possible to obtain a position in a hospital in a small community and rent a house close to my work?" In addition to letters, every mail brings professional journals which must be read for articles of immediate interest, news items which might influence our C.N.A. activities, and for our own professional growth.

Above all other things is the continuous responsibility of service to our members. This monthly column is one way through which we feel that we can reach nearly one-half of the C.N.A. membership. An important recommendation of the Structure Study is that we all increase our understanding of nursing as a national service and try to let the rest of Canada know about it too. Without being informed, no nurse can talk about nursing to a lay person. Therefore we must keep you all posted on our activities and those of allied professions.

Mental Health

Have you noticed how much more we have been hearing recently on mental health? Weekly radio programs, newspaper and magazine articles, and bulletins have all combined to make us more aware of the need for increasing mental health services. From May 3 to 9, both Canada and the United States observed Mental Health Week. Concerning this the Canadian Mental Health Association wrote:

> We are looking forward to your partnership in bringing facts relating to this enormous problem to the Canadian public. The extent of the problem, the

misconceptions with regard to mental illness, the need for more and better community resources to help people in trouble are our concern. From the cradle to the grave, wherever human beings are learning to live together, mental health plays its part. May we call upon your organization to help us bring this information to your members?

Recruitment

Perhaps in the spring of the year, a young man's fancy turns to thoughts of love but we would like to think that many young girls will turn to thoughts of nursing as a career. From all indications, the September classes will be starting to fill. The National Office mail bag is breaking forth into a rainbow of pink, blue and multicolored letters requesting information and pamphlets (too often for an English teacher's peace of mind "pamplets") about the profession of nursing. Our procedure now is to send a letter giving some of the general principles of how to choose a school of nursing and then to forward the letter of inquiry to the registered nurses' association in the applicant's own province.

Hospital Directory

The Canadian Hospital Council is preparing a Canadian Hospital Directory which will list all our hospitals and give pertinent information concerning each. This will fill a long recognized gap in our statistical source material. All administrators have probably, at one time or another, had inquiries concerning hospitals about which they had no available information. After consulting our mailing lists, the Canadian Almanac and the Hospital Administrators' Guide, we still are sometimes unable to find what we want. With the new Directory, the situation should be much improved.

Nursing Services in the Division of Indian Affairs

We have just had a most interesting visit from Miss Alice Smith, chief of nursing services of the Division of Indian Affairs. This division is a part of the Department of National Health and Welfare and, although previously under a different name, has long functioned to assist Canadian Indians in making a place for themselves in our economy. The division has 350 nursing positions, 90 of which are in the field. Besides Miss Smith, there are two supervisors, with positions open for five more. Although a public health nursing course is desirable for the field nurses, nevertheless those who have not these qualifications can be placed and given on-the-job training.

Those nurses who are employed in institutions are found largely in the Indian Affairs hospitals. Located in various parts of Canada, these hospitals give general care with, usually, an active tuberculosis unit. However, with the increasing use of B.C.G., it is hoped that the incidence of tuberculosis will decrease. If you need to be convinced of the value of B.C.G., just talk to Miss Smith. You will not be a sceptic long!

Out in the field, the nurses are accommodated in good-sized, modern houses. To take care of maternity cases and emergencies, there are a few hospital beds but no long-term care is given. A dispensary and private quarters for the nurse complete the establishment. Although temporary hospitalization is provided, this service is secondary to the health teaching that the nurse is prepared to give. She cannot be tied down in her station when there is such a great need for her out among the Indians on the reserves. Education and health go hand in hand in the philosophy of the Division of Indian Affairs. The Indian cannot become self-sufficient without provision being made for both.

Message to Her Majesty the Queen

One would not consider that preparing a message to Her Majesty Queen Elizabeth II would be very involved. The C.N.A. received a request for such a message from the

Nursing Mirror, a British journal, to be placed in a book with letters from all the other Commonwealth and colonial nursing associations. They sent us four beautiful sheets of paper, so why not just go ahead and write a message and send it to London?

How do you address a ruling monarch? How can you be sure it is correct? That is one of the functions of our State Department. All such letters must first be passed in their finished form by the Governor General. Now we come to the problem. An ordinary, common typewriter seems a little mundane to use on such an occasion. Shall we have it engraved? After inquiry, we found that this was not possible. Let us have it lettered by hand then. Telephone calls follow, looking for someone who can do it well and quickly. Remembering that the Catholic Sisters take great pride in this type of work, we went through "channels" and found an Order who had had experience in preparing an illuminated scroll when Her Majesty was in Canada. They were able to produce a fine piece of work. In the meantime the die of our crest was out at the engravers so that one sheet could have the crest in gold centred on it. Bitter blow! The crest had been in use a little too long and the engravers would not take the risk of using our precious sheets of paper. However, our good friends who print *The Canadian Nurse* were able to have the crest embossed satisfactorily on one of the sheets.

The final blow came from the blue—Ottawa approved the message and, following their procedure, *had sent it directly to Buckingham Palace!* Preparing the second copy was just like following a well worn trail.

Orientation et Tendances en Nursing

LE SECRETARIAT NATIONAL

VOUS VOUS ETES DEMANDEES sans doute bien des fois, quel est le rôle du Secrétariat National? A quoi s'occupe le personnel? Vous rencontrez parfois la registraire de votre association provinciale, mais lorsqu'il s'agit du personnel du Secrétariat National, hors le temps des conventions, vous ignorez tout de ses activités.

Les activités en cours ont tenu la secrétaire et son assistante occupées, hors du bureau, une bonne partie du temps. Durant trois jours elles ont travaillé avec les comités des assurances-santé, de l'éducation et du sous-comité de la formation professionnelle en psychiatrie (infirmières et auxiliaires). La préparation des rapports et des recommandations et leurs distributions demandèrent encore plus de temps. Ce n'est pas tout de préparer un bon rapport. Si l'on veut qu'il soit utile à quelque chose, il faut le faire connaître, en particulier à certaines personnes influentes et en général au plus de gens possible. Que d'entrevues, que de visites doivent être faites dans ce but!

Récemment nous nous sommes occupées du statut de l'infirmière émigrant au Canada. Les dirigeants du Bureau National de Placement sont venus à nos bureaux afin de déterminer la marche à suivre pour le recrutement des infirmières européennes. Bien que nous soyons tous au courant de la portée de l'Acte de l'Amérique Britannique du Nord dans les relations fédérales-provinciales en matière de santé, il est bien difficile d'expliquer cela à des néo-canadiens. Il est arrivé que des infirmières ont émigré au Canada et se sont rendu compte qu'elles n'étaient pas éligibles à l'enregistrement dans les provinces. C'est dans le but de remédier à cet état de chose et d'exercer un contrôle sur le recrutement en pays étrangers que l'aide de l'A.I.C. a été demandée.

Parmi nos activités régulières il y a l'arrivée du facteur deux fois par jour. Il apporte des demandes de renseignements des rapports de tous les coins du pays. Les secrétaires provinciales sont au courant de l'échange de correspondance entre leurs associations et le Secrétariat National.

Le Conseil International des Infirmières et des membres des autres associations nationales demandent au Secrétariat de préparer un itinéraire intéressant pour une visiteuse durant son séjour au pays; et, à notre tour,

nous demandons la même chose ou un emploi pour une de nos infirmières partant pour l'Europe. Les infirmières désirant émigrer au Canada écrivent pour obtenir des renseignements concernant l'enregistrement, la licence et les emplois. Les réponses ne sont pas toujours faciles — par exemple que répondre à celle-ci: "Je me propose d'amener ma mère qui est âgée. Serait-il possible d'obtenir une position dans un hôpital d'une petite ville et d'y louer une maison tout près?" Le courrier apporte en plus des lettres, de nombreuses revues professionnelles qu'il faut lire pour se tenir au courant des questions d'intérêt, des événements pouvant exercer une influence sur les activités de l'A.I.C. et pour notre propre développement professionnel.

La responsabilité constante d'être utiles à nos membres est ce qui nous préoccupe le plus. En écrivant cette colonne nous savons que nous atteindrons ce mois-ci la moitié des membres de l'association. A celles-là nous voulons leur rappeler une recommandation très importante faite dans le Rapport de la Structure de l'A.I.C. "de comprendre le rôle important du nursing au point de vue national, sa portée dans l'économie du pays et d'essayer de faire connaître cette idée dans tout le Canada." Si une infirmière n'est pas au courant des faits comment pourrait-elle parler de sa profession à ceux qui n'en font pas partie? Il faut donc nous tenir au courant des activités de notre profession comme de celles des professions qui lui sont connexes.

Hygiene Mentale

Avez-vous remarqué dernièrement comme on entend parler de santé mentale? Chaque semaine, radio, journaux, revues et bulletins semblent combiner leurs efforts afin de nous rendre plus conscients de la nécessité d'augmenter nos services d'hygiène mentale. Du 3 au 9 mai, on a observé au Canada, comme aux Etats-Unis, la semaine de l'hygiène mentale. L'Association Canadienne de l'Hygiène Mentale demande à toutes les organisations d'alerter leurs membres afin qu'ils renseignent le public sur cet important problème:

"Nous comptons faire connaître l'importance de la question, les idées fausses que l'on se fait au sujet des maladies mentales, les besoins de la société concernant les moyens à prendre pour aider les gens qui ont des difficultés. Personne ne doit rester indifférent. Du berceau à la tombe, partout où des humains apprennent à vivre en commun, il y a des problèmes. L'hygiène mentale y apportera d'heureuses solutions. Pourrons-nous faire appel à votre association, vous priant de communiquer ces informations à vos membres?"

Un Manuel sur la Psychiatrie

L'Association des Infirmières de la Province de Québec vient de publier "Les Relations Infirmière-Malade en Psychiatrie" de Helena Willis Render, R.N. C'est une traduction d'un classique en nursing. Nous espérons aider les étudiantes de nos écoles et les infirmières à mieux comprendre les malades en général et les malades mentaux en particulier. Ecrivez à l'*A.I.P.Q., Ch. 506, 1538 rue Sherbrooke ouest, Montréal 25, Qué.* (Le prix est **$2.50** plus frais d'envoi, 30 cents.)

Recrutement

Au printemps tout renaît dans la nature. La jeunesse est remplie d'une énergie débordante et nous aimons à croire que chez les jeunes filles cette énergie les poussera vers la carrière d'infirmière. Déjà, me dit-on, des écoles ont reçu des demandes pour l'entrée de septembre. Du courrier se détache un arc-en-ciel de lettres bleues, roses et multicolores, demandant des renseignements et un livret concernant la profession d'infirmière. Notre ligne de conduite, actuellement, est de répondre en donnant des principes généraux sur le choix d'une école d'infirmière puis nous adressons la lettre à l'association provinciale des infirmières d'où vient la candidate.

Jeunesse Ton Avenir

L'Association des Infirmières de la Province de Québec, lors de l'exposition culturelle Jeunesse Ton Avenir, a fait une grande campagne de recrutement. Tous les étudiantes des écoles, pensionnats et collèges ont visité le kiosque. Les plus jeunes se contentant d'admirer la jolie poupée infirmière tandis que les aînées demandaient des questions prouvant leur intérêt envers la profession. Le généreux concours des écoles de la province a permis de faire un succès de ce kiosque.

Le Repertoire des Hopitaux

Le Conseil Canadien des Hôpitaux est à

préparer un répertoire des hôpitaux donnant la liste de tous les hôpitaux et des renseignements se rapportant à chacun d'eux. Cette publication répond à un besoin qui se fait sentir depuis longtemps. Tous les administrateurs ont été dans l'impossibilité de répondre à une demande de renseignements au sujet d'un hôpital, n'ayant pas en main les informations nécessaires. Même nous, après avoir consulté la liste de nos correspondants, le "Canadian Almanac" et le guide des administrateurs des hôpitaux, nous ne trouvons pas toujours le renseignement dont nous avons besoin. Ce nouveau répertoire rendra de grands services.

Les Infirmieres au Departement des Affaires Indiennes

Nous venons de recevoir la visite de Mlle Alice Smith, infirmière en chef au service du nursing du Département des Affaires Indiennes, visite des plus intéressante. Ce département fait partie du Ministère National de la Santé et du Bien-Etre. Le but de ce département est d'aider les Indiens du Canada à prendre place dans l'économie canadienne. Le département emploie 350 infirmières dont 90 sont dans les réserves. En plus de la directrice, Mlle Smith, il y a deux surveillantes et l'on en désire cinq autres. Les infirmières hygiénistes sont les mieux qualifiées pour ces postes et celles qui n'ont pas ces qualifications peuvent recevoir une formation au travail.

Ces infirmières travaillent dans les hôpitaux du Département des Affaires Indiennes. Ce sont des hôpitaux généraux dont une partie est réservée au traitement de la tuberculose aiguë. Toutefois, avec la vaccination intense au B.C.G., il est à espérer que la tuberculose diminuera. Si vous avez des doutes au sujet de la valeur du B.C.G., parlez-en à Mlle Smith. Vos doutes s'évanouiront vite!

Dans les réserves, les infirmières sont logées dans de grandes maisons modernes, contenant une salle de quelques lits pour les cas de maternité et les cas d'urgence, un dispensaire et le logis de l'infirmière. Bien que quelques malades soient parfois hospitalisés, le principal travail de l'infirmière consiste dans l'enseignement de l'hygiène. Elle ne peut pas rester à un endroit pour soigner les malades. Il y a trop de travail à faire parmi les Indiens de la réserve. C'est en ayant l'instruction et la santé que les Indiens peuvent devenir économiquement indépendants. C'est le but que se propose d'atteindre le Département des Affaires Indiennes.

Une Lettre a Sa Majeste la Reine

Le Secrétariat Général n'aurait jamais cru devoir préparer un message pour Sa Majesté la Reine Elizabeth. Le *Nursing Mirror*, une revue anglaise, nous demanda de préparer une lettre. Toutes les associations nationales d'infirmières du Commonwealth Britannique feront de même. Les lettres seront reliées en un volume et présentées à la Reine. Nous avons reçu de Londres quatre feuilles d'un papier magnifique. Mais comment s'adresse-t-on à la Reine? Cela relève du Parlement. Toutes les lettres doivent être vues en dernier lieu par le Gouverneur Général.

Une fois renseignées à ce sujet nous nous sommes mises à l'oeuvre. Une lettre écrite au dactylo ne convient pas. Peut-être pourrions-nous faire graver le message? Non, cela ne se fait pas, donc il faut l'écrire à la main. Nous nous sommes rappelées que les religieuses catholiques excellaient dans ce genre de travail et nous avons trouvé une Communauté qui avait déjà enluminé une adresse pour Sa Majesté, lors de son passage au Canada. Elles ont fait un très beau travail. Entre-temps nous désirions que le sceau de l'Association des Infirmières du Canada soit gravé en or sur la feuille. Voilà que notre sceau est trop usé pour permettre un beau travail! Heureusement que l'imprimeur du *Canadian Nurse* est venu à notre secours, enfin tout allait bien. Le message fut envoyé à Ottawa . . . nouvelle épreuve — selon leur habitude, une fois approuvée, la lettre fut envoyée directement au Palais de Buckingham! Il nous a fallu tout recommencer, mais cette fois nous savions comment faire!

We need to mature our mentality so that it catches up with our technics, instead of getting along with a way of thinking and feeling that was appropriate in a technically simpler age. Only thus can we hope to pass through the middle years of our lives without the sense of frustration and failure that is all too common among middle-aged people. It is not in terms of years that maturity is to be measured, nor yet in terms of knowledge. To be mature is to use knowledge wisely.

—*The Royal Bank of Canada* Monthly Letter.

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ETHEL ARMSTRONG COLLINS

UN REVE LONGTEMPS caressé, enfin réalisable! Un voyage aux Montagnes Rocheuses! Des vacances dans un des hôtels les plus luxueux du monde à un prix modique. Faites du magnifique Banff Springs Hotel, votre demeure durant une semaine—c'est là que se tiendra le 27e congrès biennal.

L'inspiration et le succès ne devront pas manquer aux nombreuses congressistes qui se rendront à cette réunion.

On peut aussi s'amuser dans un congrès, il n'y a pas que du travail. A Banff, la natation dans la piscine intérieure ou extérieure, dans les eaux chaudes de la source sulfureuse, est un des sports favoris; venez exercer votre adresse sur le terrain de golf s'étendant sur une pente d'un mille; la montagne vous offre de délicieuses promenades à pied, à cheval, et des ascensions magnifiques. Faites des excursions, tout en admirant les beaux paysages. Voyez le Lac Louise; les lacs perdus au-dessus des nuages; la Vallée des Dix Pics; le Lac Emeraude; la Vallée Yoho; ou les glaciers de la Colombie.

Le voyage à l'aller sera plein d'entrain. Des trains spéciaux partiront de Montréal, Toronto et de Vancouver. Au retour, vous pouvez revenir par les grands lacs de Fort William à Port McNicholl, puis de là par train jusqu'à la ville où vous habitez. Cette croisière sur le *SS. Keewatin* ou sur *l'Assiniboia* est un intermède agréable et reposant. Mais oui, deux semaines de vacances suffisent pour faire tout cela.

Banff Springs Hotel

to Lake Louise, the Lakes in the Clouds, Valley of the Ten Peaks, Emerald Lake, Yoho Valley, or the Columbia Ice-Fields.

The trip *to Banff* will be fun, too. Special trains will be run from Montreal, Toronto, and Vancouver. If they wish, Easterners may return via the Great Lakes from Fort William to Port McNicholl, thence by rail to their home town. This restful trip on the *S.S. Keewatin* or *Assiniboia* provides a pleasant and relaxing interlude. *And* all this can be done in two weeks!

Plan to take one of the post-convention trips, if you have more time to spend:

1. Leaving Banff, go via the Kicking Horse Pass and spiral tunnel, over the Great Divide, through the majestic mountain scenery to Vancouver. After 24 hours there, sail across the Straits of Georgia to Victoria, for two full days at

Après le congrès, si vous désirez continuer votre voyage, voici quelques suggestions:

1. En partant de Banff, rendez-vous à Vancouver par la Passe-du-Cheval-qui-rue en passant sous le tunnel qui monte en spirale. Voyez de vos yeux la ligne de partage des eaux—The Great Divide—et tout le long du chemin, admirez un paysage magnifique où la nature s'est surpassée. Après un séjour de 24 heures à Vancouver, traversez le Détroit de Georgie pour arriver à Victoria et y demeurer deux jours. Un autre hôtel luxueux, l'Empress, vous offre le charme des hôtels européens et ses fleurs magnifiques. Que d'agréables excursions à faire—la Malahat Drive, Oak Bay et les jardins Butchart dignes d'une Simiramis. Durant l'après-midi vous reprenez le bateau qui vous ramène à Vancouver et à votre train.

2. Faites une croisière de huit jours

another luxurious hotel—the Empress, with its old world charm and gorgeous flowers. Drive over the Malahat, visit Oak Bay and Butchart's Gardens. Then in the afternoon sail back to Vancouver to connect with homeward-bound trains.

OR

2. Take an eight-day cruise to Skagway, Alaska, through the inside passage; calls are made at Prince Rupert, Ketchikan (totem poles); Wrangell and Juneau. From Skagway, side trips may be taken to the interior of Alaska.

OR

3. Fly to Hawaii! One week's all-expense tour in this tropical mid-ocean playground! Visit Honolulu, Pearl Harbor, and swim at Waikiki Beach. See pineapple and sugar plantations; volcanoes; acres of orchids; native dances. You will enjoy the gracious custom of the flower leis. Over you will steal the spell of these islands — their fragrance, their sunshine and their laughter — a charm that belongs only to Hawaii.

Further particulars, including prices, will be published in a later edition of *The Canadian Nurse.*

Plan Now to Attend!

—ETHEL ARMSTRONG COLLINS

au pays du soleil de minuit. Rendez-vous à Skagway en Alaska en longeant les passes; arrêtez à Prince Rupert, à Ketchikan voir les totems, à Wrangell et à Juneau. De Skagway, visitez l'intérieur du pays.

3. Par avion rendez-vous à Hawaï. Un voyage d'une semaine tous frais compris, dans un jardin tropical de l'océan. Visitez Honolulu, Pearl Harbor, nagez de la plage de Waikiki, voyez les plantations de cannes à sucre et d'ananas. La gracieuse coutume des colliers de fleurs vous plaira et vous emporterez avec vos "leis" l'enchantement des îles, leur parfum, leur lumière et leur gaieté—le charme unique de Hawaï.

Des détails supplémentaires, dont le prix de ces voyages, seront publiés plus tard dans *The Canadian Nurse.* Préparez-vous dès maintenant à partir!

—ETHEL ARMSTRONG COLLINS

In the Good Old Days

(*The Canadian Nurse* — JUNE 1913)

"MY CLOSING ADVICE to you is: Wherever you go on your mission of mercy, whether in the home, the hospitals or on the field of battle, go with the determination to do your best, to bring sunshine into the sick room and to help everyone with whom you come in contact."

* * *

"But while at the present moment no war clouds darken our horizon, and the Angel of Peace hovers over the Empire, and while we all hope that such a state may long obtain, still we wish to feel that if War, with its attendant horrors, should ever come, the nursing reserve will be able to take its place in the great fight, will always be found ready for every duty, equipped for every work, and equal to every emergency."

* * *

An Act respecting The Manitoba Association of Graduate Nurses — "No person shall be entitled to be registered after the coming into force of this Act, unless he or she shall have followed a regular course of training . . . for at least three years within a recognized hospital having a daily average of *five* patients, where there may be a complete course of training, or in any hospital maintaining a training school but with less than an average of five patients daily, provided that such hospital is affiliated with a larger hospital where the course of training hereinbefore provided may be completed. . ."

* * *

Nursing taught by mail — "Publicity and legislation should not invade any sphere in which correspondence schools may do useful work and serve a good purpose. The correspondence school may be perverted to the profit of charlatans and become a menace to society, when its immediate activities capture the pennies of young women who imagine they can be taught nursing by mail, and its ultimate activities may endanger the lives of people . . . The noble profession of nursing should be as carefully guarded from the ravages of the charlatan as the profession of medicine."

If you adequately satisfy all of an infant's needs, he grows up to be a loving, harmonic, cooperative personality. This we can now prove. —ASHLEY MONTAGU

(Nursing Outlook, Feb. 1953)

Student Nurses

Worthy of the Title

ALISON BARKER

THE PROBLEM

NURSING, WE HAVE BEEN TOLD, is an art and a science. Exactly what does that mean? An *art* is a body of practical knowledge that tells how to work to produce certain results. A *science* is a body of collected knowledge based on a large number of facts arranged and classified in such a way as to establish certain laws and principles. Above all, nursing is a *profession* which serves all humanity.

To be a nurse worthy of the title means having many obligations to carry out and, perhaps, some hardships to undergo. Because the patient is the most important person, in our orbit, we must do our best to relieve his pain, help restore his strength, treating him always with kindliness. We must be loyal to our school of nursing, the nursing profession, and the hospital. We must be practitioners of good health in our own ways of living. Silent, cheerful, kind, poised, confident, tactful, and dependable — all these apply to the nurse of quality.

This is the kind of nurse I want to be.

THE METHOD

As a student nurse I must learn my work thoroughly so that when attending a patient I will be able to *inspire confidence* in him. If the patient is given this confidence he will be at ease and ready mentally as well as physically for the ensuing treatment and procedures.

Sympathy is the art of being able to understand and comfort a person when depressed. Understanding and sympathy go hand in hand. A sick person naturally hasn't the best outlook on life and his main contact with the outside world is the nurse. If a nurse has sympathy and understanding for her patient she will realize that any thoughtful little act, such as bringing books for him to read or writing letters for him when he is unable to do so, means much to the patient yet takes little effort on her part. The little kindnesses give our patients the feeling that someone still thinks about and is interested in them. Yes, I shall be sympathetic, understanding, and thoughtful with my patients.

Along with the other characteristics of a good nurse, *self-control* is important. To be self-controlled means to control one's emotions. Many times during our student years we will make mistakes. No one is perfect, so we must be able to accept constructive criticism when it is given to us. Anger will not make friends and resentment will not improve the kind of work we do. It is also necessary to control any revulsion felt at the sights we may see when on the wards. The patients themselves feel uncomfortable when being cared for and they will not be helped by the thought of a nurse showing distaste at the sight of them.

Panic has no place in a nurse's character. We must remember that the hospital and its staff are responsible for the occupants. If a nurse loses control of her nerve in a critical situation, for example a fire, many patients' lives could be lost. *Calmness* saves lives.

How many friends we can lose through lack of *tact* and *discretion!* Nurses must be discreet and tactful when discussing illness in front of

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When she was a preliminary student at the Regina (Sask.) Grey Nuns' Hospital, Miss Barker wrote this summary of her thinking. Now as she nears graduation we hope her dream is well on the way to being realized.

patients, to visitors, and with the hospital staff. Silence is still the best policy. The in's and out's of hospital life must be kept within its walls.

Conversation is the art of exchanging ideas between two or more people through the medium of words. One must also remember that to be a good conversationalist one must be a *good listener*. Everyone likes to talk about himself, his family, his friends, his ideas and his hobbies. By listening carefully to the patient, a nurse may be able to make valuable observations regarding him; she should be able to converse upon a number of generalized topics and so avoid personalities; she should never gossip *about* the patients, nurses, doctors or lay staff with anyone in the hospital or outside.

A good nurse must be a *quiet* nurse. Any unnecessary noise is absolutely out of place. For complete rest and peace of mind, the patient must have quiet surroundings. That means no senseless chattering or giggling in the corridors, too.

Good manners are definitely an asset. We must remember that for the duration of his stay in hospital the patient's room is his home. If his door is closed, knock before entering. Whenever attending the patient make sure the bed is screened. Give him the same kind of privacy you would want yourself.

The hospital, however, does not consist of patients alone. There are numerous staff members. Everyone must *learn to cooperate* with others so that this great institution may run smoothly.

Neat, clean, healthy and fresh are adjectives that describe a good nurse. How can a nurse possibly teach good health habits to the patients if she herself isn't healthy. Simple things to remember are neat hair, a clean uniform and good posture, so that when entering the ward you will be pleasing to the eyes of the patients.

Yes, I must remember to practise all these things and many more if I want to be worthy of the title of nurse. If I am courteous and imaginative it may not be too difficult.

Now we have arrived at a very important point — the reason for my decision.

The Reason

What better way could I find to serve my fellow man and our Creator? Nothing could give me more satisfaction and sense of accomplishment than to relieve the suffering of a human being — man, woman or child.

I want to be a nurse of the highest calibre and strive for perfection because I want my parents, my friends and my fellow workers to be able to say truthfully, *"There is a good nurse."*

Book Reviews

Handbook of Diet Therapy, written and compiled by Dorothea Turner, for the American Dietetic Association. 138 pages. J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. Revised edition, 1952. Price $3.50.

In the six years that have elapsed since the first edition of this book was published, diet therapy has become a more and more valuable adjunct of medical treatment. To meet this trend new material on diabetes and the sodium-restricted diet has been prepared, as well as carefully thought out instructions and tables dealing with adaptations of the normal diet to meet special needs.

A committee of the Diet Therapy Section of the American Dietetic Association made detailed study of how to meet the body's needs for the essential vitamins, minerals, and nutrients. Many useful pointers are given. For instance, "the vitamin A content of low-fat diets, as served in various hospitals, was extremely low unless liver was served at frequent intervals." Persons who are placed on a low-sodium diet may be getting sodium from unsuspected sources — foods processed with sodium preservatives, medications and, in some cases, drinking water.

There are many tabulations of various kinds — the amino acid content of foods, the sodium content, caloric values, etc. The confusion that has arisen from naming

special kinds of diets after their originators has been eliminated.

While this book would be useless as the preliminary text in nutrition for student nurses, it is an exceedingly valuable guide for senior students and graduates. They will have a much better understanding of the purpose special diets are intended to serve.

A Handbook for the Blind, by Juliet Bindt. 244 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1952. Price $4.00.

Reviewed by Sister H. Bellec, Supervisor, St. Boniface Hospital, Man.

From cover to cover, we meet the decisive challenge confronting the sightless and we ask ourselves, "How sightless do we consider them?" "What special needs have they?"

In her dedication, the author sets forth clearly the desire of a newly blinded couple to live a normal, righteous life among friends and acquaintances. She aids them by her own personal experiences and fills them with a consciouness that, although they have no sight, they are capable of living a fuller, happier, more normal life by challenging their obstacles.

Her book is developed in three distinct parts. The first is meant to aid the blind persons in achieving their desired end. They are shown how to make use of their remaining senses to adjust themselves to their specific environment, care for their own mental and physical needs — food, clothing, travel, personal appearance, recreation, and full family life as well as business.

The second part drives home a very pointed and clear lesson to the people who have full use of their five senses. It shows them the need to stimulate within the blind person's heart the feeling of independence without a tinge of regret or inferiority because of their visual handicap.

The author points out clearly how blind people must be welcomed into human society, as beings with personal problems. Before this can be done all preconceived ideas of the apparent handicap under which a blind person lives must be abandoned. In conversing with, offering assistance to, or guiding the blind person we must do so with a gesture of confidence both in the person's ability and our desire to assist.

The third division deals with the "deaf-blind" persons, who are generally sorely discouraged by having to live without sight or hearing. The great need of patience, perseverance and fortitude, along with confidence in their own abilities, is evident.

At the conclusion of her book Mrs. Bindt expresses a desire that the human race in general may have a clearer and more helpful understanding of the problems of the sightless and that the sightless in return may receive courage, patience, alertness and that imagination so necessary in combatting their trials of life and their great handicap.

The Encyclopedia of Nursing, by Lucile Petry. 1,011 pages. McAinsh & Co. Ltd., 1251 Yonge St., Toronto 5. 1952. Price $4.75.

Reviewed by Pauline Capelle, Asst. Professor, School of Nursing, University of British Columbia, Vancouver.

This material meets a real need of the professional nurse since it provides a ready source of reliable reference material applicable to the art and science of nursing. This point is well illustrated by the first entry in the book — the word "abbreviation." Defined clearly and simply, there follows a concise statement of the origins of abbreviations. It concludes with the use of abbreviations in nursing. The dangers inherent in the misinterpretation of abbreviations, particularly in prescriptions, is drawn to the reader's attention and should prove an effective deterrent to errors.

The descriptions of various disease entities emphasize those factors that give the nurse a basis for understanding her patient's condition. The discussion of the disease is followed by a consideration of the nursing treatment program. This is basic in the recognition of nursing as a profession as well as being an excellent reference in planning quality nursing care.

Another valuable feature is the interpretation of the various tests used in the diagnosis and treatment of disease. The nurse not only learns the norms and significant deviations but also how specimens should be taken and cared for. The encyclopedia gives reliable data in relation to the basic nursing sciences of chemistry, physics, biology, anatomy, physiology, and psychology.

The book itself has a sturdy attractive cover, is well bound, and has good quality paper. These features should enable it to stand up to the hard wear that its users

will undoubtedly give it. The employment of different kinds of type and cross-indexing facilitates location of desired information. The appendix, with its lists of current abbreviations, prefixes and suffixes, symbols and tables of weights and measures, provides another source of quick, easy reference.

It would seem that the publishers have more than attained their goal of "presenting to the nursing profession the first comprehensive encyclopedia planned, written and published solely with the objective of instructive and reference value in nursing." That the book is free from verbosity is no small accomplishment and adds materially to its value.

Infectious Diseases — with chapters on Venereal Diseases, by A. B. Christie, M.D. 336 pages. British Book Service (Canada) Ltd., 1068 Broadview Ave., Toronto 6. 2nd Ed. 1951. Price $5.00.
Reviewed by Mary E. (Dunsmore) Hall, formerly with Sudbury (Ont.) Branch, Victorian Order of Nurses.

Dr. Christie has succeeded in presenting his subject with enthusiasm and forcefulness to the extent that he stimulates his readers to an active interest in the rise, spread, control, and social aspects of infectious diseases. He transforms communicable disease study from purely an "examination" subject into an exciting quest for knowledge of effective management methods.

In Part I a clinical study of disease is presented in orderly, lucid fashion by one who has had firsthand experience with his subject as physician, medical health officer, and lecturer. He has included diagrams, charts, and color plates to clarify and fortify his remarks. The opening chapters contain concise, pertinent, bacteriological material designed to give the nurse a practical approach to the epidemiological aspects of disease. Here and throughout the book preventive methods are stressed.

Part II is devoted to the social approach and public health measures. While Canadian readers should find this section of interest from a comparative point of view, some of the material provided is applicable only to practice in England. This is particularly true of the chapter on immunization.

In the main, Dr. Christie has achieved his aim of providing nurses with a workable knowledge of communicable diseases. In addition he makes a strong appeal to nurses

to take a more intelligent interest in the wider manifestations of these diseases — not only the sources of infection, methods of spread and of control but also the effect produced on the individual himself and his environment. Student nurses and teachers will find this a valuable source book and public health nurses will find in it much interesting and helpful material.

In Memoriam

Mrs. Gladys Adams, a native of New Brunswick, who served overseas with the C.A.M.C. during World War I, died recently in Nokomis, Sask., at the age of 64.

* * *

Gertrude Billyard, who graduated with the first class from St. Boniface (Man.) Hospital in 1903, died in Winnipeg on March 10, 1953. During World War I Miss Billyard served overseas for four years with the C.A.M.C., was mentioned in despatches and received the Royal Red Cross.

* * *

Mary Emily Thelma (Martyn) Curtis, who graduated from the Peterborough Civic Hospital in 1928, died at Fenelon Falls, Ont., on February 20, 1953, following a lengthy illness. Mrs. Curtis was 47 years of age.

* * *

Mary Magdalen (O'Shaughnessy) Donnelly, a graduate of Hôtel-Dieu, Kingston, Ont., died on February 28, 1953, in Sudbury, Ont., following an illness of two months. She was in her 43rd year.

* * *

Mary Finlayson, who graduated from St. Paul's Hospital, Vancouver, in 1914, died in New Westminster, B.C., following a long illness.

* * *

Gertrude (Cosgrove) Hourigan, who graduated from St. Vincent de Paul Hospital, Brockville, Ont., in 1925, died there on March 11, 1953, following an illness of several months. She was 56 years of age. Mrs. Hourigan had been superintendent of nurses at St. Vincent de Paul Hospital for some years prior to her illness.

* * *

Annie (Graham) Jackson, who was matron of her own nursing home in Winni-

peg until her retirement in 1940, died in Winnipeg on March 1, 1953, at the age of 80.

* * *

Edythe Jane May, who graduated from The Montreal General Hospital in 1916, died suddenly on March 4, 1953, in Montreal. Miss May had spent most of her professional life in private nursing. She retired 15 years ago.

* * *

Frances (Dionne) Mayr, who graduated from St. Joseph's Hospital, Saint John, N.B., in 1944, died in Aberdeen, Oregon.

* * *

Mary Anne Murphy, who graduated from The Montreal General Hospital in 1920, died in Montreal in March, 1953. Miss Murphy had engaged in private nursing for many years.

* * *

Florence May Palen, who graduated from the Ottawa Civic Hospital in 1932, died in Ottawa on March 19, 1953, at the age of 46. Miss Palen had been in indifferent health for many years.

* * *

Emma Sharp, who graduated from the Kingston (Ont.) General Hospital in 1930, died there suddenly on November 29, 1952. Miss Sharp had been a member of the K.G.H. staff for many years, most recently as supervisor of the out-patient department.

* * *

Sister Helen Morrissey, a graduate of Hôtel-Dieu, Montreal, died there on April 9, 1953, at the age of 92. Following graduation Sister Morrissey was placed in charge of the pharmacy and built it up to be an outstanding department. When Hôtel-Dieu opened an English branch in 1923, Sister Morrissey became superior of the newly formed St. Mary's Hospital. Later she returned to the English-speaking wards at Hôtel-Dieu. She was the author of two books.

* * *

Sister Marie Ange, of the Community of the Sisters of Providence, died in Calgary, Alta., on February 16, 1953, at the age of 81. A pioneer in Alberta mission hospitals, Sister Marie Ange opened the first hospital at Grouard in 1912. Later she opened a new hospital at Fort Vermilion. For several years she was superior of the hospital at McLennan. She retired to Midnapore in 1938.

A WAIVER IN ONTARIO UNDER THE NURSES' REGISTRATION ACT — 1951

Notice is hereby given that the regulations under the Nurses' Registration Act, 1951 (Ontario) include a waiver which reads as follows:

"The Board shall register without examination any person
(a) who
  (i) graduated from a school of nursing, and
  (ii) was eligible for registration as a registered nurse under any Act of this Legislature before the year 1926; and
(b) who has not registered as a registered nurse where that person
(c) applies for registration before the 31st of December, 1953, and
(d) pays the registration fee prescribed by sub-Regulation 2 of Regulation 12."

For interpretation of eligibility and for individual application write to the **Registrar, Registered Nurses' Association of Ontario, 515 Jarvis St., Toronto 5, Ontario,** stating name and location of School of Nursing, and year of graduation.

Alberta

The following is staff news from the Alberta Division of Public Health Nursing: *Helena Pankow* (General Hospital, Vegreville, Alta.) is stationed at Grassland. A graduate of the Royal Maternity Hospital and So. General Hospital, Glasgow, Scotland — *Janet Gavigan* — is at Plamondon. *Mrs. Edith A. Bennett* has transferred from Grassland to Breynat. *Marguerite Ries,* having completed the advanced course in practical obstetrics, has taken up duties at Valley View.

Ontario

The following nurses have resigned from the Ontario Public Health Nursing Service: *Gene Clark* as public health nursing supervisor, Peterborough; *Caroline (Moorhead) Holland* from York County health unit; *Marjorie (Broadbent) Macfarlane, Eileen McCready,* and *Edith McOuat* from Timiskaming health unit.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments — Burlington, Ont.: *Mrs. Audrey Anderson* (Hamilton Gen. Hosp.). Halifax: *Margaret Ann Schaffner* (Victoria Gen. Hosp., Halifax). Hamilton: *Elsie Farrell* (H.G.H.) and *Mary Janzen* (H.G.H.). Lincoln County, Ont.: *Lucy Dalicandro* (St. Joseph's Hosp., Hamilton) and *Betty Link* (H.G.H.). Winnipeg: *Clarice Diamond* (Winnipeg Gen. Hosp.).

Transfers — *Valda Howard* from Timmins to Sudbury; *Mrs. Agnes MacDonald* to be in charge at Kirkland Lake; *Isobel Simister* from Kirkland Lake to Timmins as nurse in charge.

Resignations — Brockville: *Mrs. Jean Lorimer.* Chatham, Ont.: *Blanche Hillier.* Hamilton: *Mary MacCallum.* Kitchener: *Mrs. Beverly Read.* Lincoln Co.: *Clara Hood.* Newcastle, N.B.: *Mrs. Bettie Norris.* Saint John, N.B.: *Audrey McIntyre.* Vancouver: *Bernice Gordon, Mrs. Freda Henderson.*

Nursing Sisters' Association

The following officers will serve during the coming months for the *Montreal Unit:*

President, A. W. Lindsay; vice-president, I. Henderson; secretary, C. M. Dibblee; treasurer, P. Bisaillon. Committees: Visiting — for Montreal, Mrs. Toller, and for Ste. Anne de Bellevue, N. Kennedy-Reid; social, G. Layman. E. Groenewald and L. Payn are on the special committee and D. Marks and K. MacLeod will serve in other capacities.

News Notes

ALBERTA

COLEMAN

At the March meeting of the Crow's Nest Pass Chapter it was decided to continue the nurses' scholarship and plans were made to hold a refresher course for inactive nurses, as part of the preparedness plan for Civil Defence. Mrs. A. Vejprava and M. Kunik were appointed to attend the A.A.R.N. annual meeting.

Officers elected for 1953 were: President, Mrs. E. Bruning; vice-president, M. Berze; secretary, H. Clemis; treasurer, Mrs. A. Lord; press correspondent, Mrs. M. Dunford; executive committee, Mmes Vejprava, A. Skiffington, V. Halderson.

At a later meeting, held at the home of Mrs. A. Skiffington, the president, Mrs. E. Bruning, was in the chair. The following members were appointed to the Scholarship Committee: M. Johnson, M. Allan, N. Bayon. A scholarship, valued at $100, will be awarded to a Grade XII graduate who has been accepted by a School of Nursing. A. Murdoch and J. Smithson were appointed to the Visiting Committee.

An interesting panel discussion on the C.N.A. Structure Study took place, the participants being: M. Johnson, M. Berze, H. Clemis, N. Bayon, P. Wojutla, M. Allan, J. Dunford.

JASPER

Ten members of Edith Cavell Chapter met in March at the home of Mrs. Banner, whose report of the Red Cross meeting led to considerable discussion. All were in favor of the reorganization of a local Red Cross. At the social hour which followed Mrs. Currie was presented with a going-away gift.

A later meeting was held at the home of Mrs. Brodic, when matters under discussion were: Inoculation of children starting school in the fall and the plan for setting up a potential blood bank by having each member find two prospective donors. The latter project was the outcome of a talk by Dr. Betkawski in which he explained the Rh factor and stressed the advantage of having a supply of blood available.

CALGARY

General Hospital

At the annual meeting of the alumnae in March, the director of nurses, Miss G. M. Hall, spoke on the progress of nursing. It was decided to make donations to the Community Chest and the Cancer Fund.

B. Johnstone and her committee served refreshments.

BRITISH COLUMBIA

PRINCE GEORGE

T. Fagan, who has been O.R. supervisor at the Prince George and District Hospital, will be replaced by Mrs. D. Scott while the former takes a post-graduate course in surgical nursing at St. Joseph's Hospital in Victoria. Mrs. Scott is a graduate of the Victoria General Hospital, Halifax, and was previously on the O.R. staff of Vancouver General Hospital.

REVELSTOKE

I. L. Peressini has been appointed to the Queen Victoria Hospital as superintendent of nurses and Mrs. E. Gable as head nurse. The resignation of Mrs. D. Dickie from the former position was accepted with regret.

WILLIAMS LAKE

Seven members of the local branch travelled to Quesnel in March to assist in the formation of the Cariboo District of the R.N.A.B.C. Twenty-six members of the Quesnel Chapter were on hand and it is hoped that the Prince George nurses will join shortly. The Quesnel president, Mrs. Ramsay, presided, while Alice Wright, R.N.A.B.C. registrar, was guest speaker. M. Lang, Quesnel Hospital matron, was elected president of the district group, with E. Holley as vice-president, Mrs. P. Yaholnitsky, secretary-treasurer, and the councillor, Mrs. Haggart.

The members who attended from Williams Lake included the president, Mrs. C. Singer; B. Page, E. Holley, A. Wiens, Mmes L. Godfrey, J. Stitt, L. O'Fee.

NEW BRUNSWICK

MONCTON

Mrs. N. Smith presided at the meeting of Moncton Chapter in April when various reports were read.

The Block System, which has been introduced in the Moncton Hospital, was discussed, and comments regarding the Structure Study were led by Mrs. R. Perry. Dr. A. Dobson gave an interesting talk on "Present-Day Anesthesia."

SAINT JOHN

Upwards of 350 attended an enjoyable dance sponsored by the Saint John Chapter. His Honor the Lieutenant Governor and Mrs. MacLaren and His Worship Mayor E. W. Patterson and Mrs. Patterson were among the patrons for this event. D. Dykeman was the convener for the arrangements, assisted by B. McCarthy and Mrs. B. Bloom.

NOVA SCOTIA

COLCHESTER COUNTY BRANCH

At the February meeting, held in Truro, the guest speaker, Rhoda MacDonald, warned against forgetting the art of nursing in the preoccupation with scientific techniques. She also spoke on nursing to the high school students, at the request of the local branch. The recent rummage sale was a successful fund-raising project.

The Film Council has arranged to hire a projector for the use of patients in the Colchester Co. Hospital.

HALIFAX

Dalhousie University
School of Nursing

An institute on "Nursing Aspects in Mental Hygiene" conducted by the School of Nursing proved most successful. The peak registration reached 200 which was far beyond the expectation of the School. Miss Elsie Ogilvie, nursing consultant, American Psychiatric Association, was the chief discussant and presented a paper on "Professional Preparation for the Field" on the third day. Drs. R. O. Jones, R. J. Weil, F. A. Dunsworth, and Frances Marshall presented the medical aspects of mental hygiene. The nursing aspects were discussed by Misses L. O. Smith, M. Shore, A. Munro, and D. Gill. The large amount of audience participation contributed greatly to the success of the conference.

Interested registrants included: Superintendents of nurses and staff nurses of general hospitals, sanatoria, children's hospitals, and psychiatric hospitals; hospital teaching staff; supervisors and staff from official and voluntary public health nursing agencies; and various sessions were attended by students in medicine, social work, and nursing.

Rearrangement of the B.Sc. in Nursing course has resulted in a re-wording of the description of the course in the calendar. Prospective students should write the Registrar for details.

YARMOUTH

A symposium dealing with the generalized public health program was presented by various speakers at a meeting of the Atlantic Branch of the Canadian Public Health Association. The different fields of public health were discussed as follows: Miss M. Walker, industrial nursing; Miss G. Crosby, school health program of Halifax; the late Miss Lenta Hall, V.O.N. services; Miss F. Fraser, Dalhousie public health clinic; Miss M. MacLellan, provincial public health services. Lively discussion followed.

ONTARIO

DISTRICT 2

BRANTFORD

Shirley Preece, who graduated last June from the General Hospital, has left for South Africa to take up missionary work. On graduation she was the recipient of the Perley Memorial Award and the Dr. J. A. Phillips Award for proficiency in medical nursing.

SIMCOE

In the absence of the president, M. Cheetham, Mrs. A. Schier took charge of

the meeting of the nurses' association of Norfolk General Hospital in March.

The treasurer, H. Courtney, announced the substantial proceeds of the June tea, rummage sale, and other activities. D. Bowden read two letters of thanks from the Board of Governors for special equipment donated during the year.

The following officers were elected: Honorary president, D. Bowden; president, Hazel Johns; vice-president, Mrs. Shier; secretary-treasurer, H. Courtney; flower convener, Mrs. N. E. Werrett; social and entertainment conveners, D. Stuart, S. Matthews; press secretary, Mrs. H. Noble.

Refreshments were served under the convenership of B. Clark.

District 3

Chesley

E. M. Schaab presided at a meeting of the Nurses' Auxiliary of Chesley and District Memorial Hospital when a film was shown on public health services in British Columbia. Mrs. G. Buckland reviewed the new book — "Practical Nursing." After discussion, the members decided to change the rates for private nursing to $8.00 for an eight-hour shift. Mrs. F. Hood replaces Mrs. J. Hetherington on the Visiting Committee. Twenty-five dollars was voted towards the Canadian Save the Children Fund and it was announced that Mr. and Mrs. F. Durst had donated a gift to the nursery in memory of the late Mr. W. G. Durst.

Irma Ternan, on the staff of the Bruce County health unit, gave an address on the special course she had attended in Toronto on "Natural Childbirth." She will lecture to the nurses in her area.

Refreshments were served by Miss Schaab, Mmes G. Dods, W. Krug.

Guelph

Marnie Wilson of the staff of Duncan McPhee addressed the members of the General Hospital Alumnae Association at a regular meeting, with L. Campbell presiding. Miss Wilson spoke on "Interior Decorating," with an eye to colors depicting personalities, hobbies, nature, themes, and practicability. B. Reid introduced the speaker, who was thanked on behalf of the members by L. Ferguson.

Five new graduates were accepted as active members.

Hanover

Miss G. Saunders, retiring superintendent at the Memorial Hospital, was honored by the nursing staff and other nurses, when they gave a farewell dinner for her. D. Widmeyer expressed the regrets of those present and tendered their good wishes. On behalf of the guests, Miss Fisher presented Miss Saunders with a travelling case. Bridge was enjoyed following the dinner.

District 5

Toronto

General Hospital

As a result of the annual meeting of the Alumnae Association the new executive is as follows: President, E. Stuart; vice-presidents, M. Strong, J. Dodds; councillors, B. Mummery, C. McKinnon, J. Lepan, H. McLaren.

Changes on the staff of the hospital include: J. Cameron, nursing arts instructor; M. Johnson, J. Hilditch, clinical supervisors; J. Murdoch, J. Scrimgeour, Miss Henderson, G. Holmes, head nurses; S. Howard, assistant head nurse; Miss Franklin, in charge of the recovery room.

J. Hickling is on the staff of the Canadian National Institute for the Blind, with headquarters at Willowdale. E. Armstrong is the school nurse at Moulton College.

Out of the city are: D. James, on the O.R. staff of the New York Hospital; L. Evans is at the Cedars of Lebanon Hospital, Los Angeles; doing general duty at the Massachusetts General Hospital, Boston, are S. Malabar, J. Corner, J. Sutherland, C. Bagnell; M. McTavish and J. Butt are taking a course at Montreal Airport before beginning their duties as stewardesses with T.C.A.; E. Hanna is with the V.O.N. in Ottawa; J. Bates is industrial nurse at Square D Electrical Co. in Mt. Dennis; H. Bryson will be with the R.C.A.F. in Germany for two years; M. McPhee is doing general duty in New York; T. Richards and M. Stinson are with the A. V. Roe Co. at Malton and M. Cleland is taking post-graduate work at U.W.O., London.

B. Hain is with the O.R. at Lachine General Hospital, Que. R. Jackson is assistant superintendent of nurses at the Toronto East General Hospital and R. McDonald on the staff of the Dept. of Public Health in Toronto.

Women's College Hospital

Applications are now being received for the scholarship donated by the Board of Governors for post-graduate study in Teaching or Administration in Schools of Nursing. M. Newman and B. Russell have completed the stewardess course and are now with T.C.A. Mrs. J. Smith is in the O.R. at Lockwood Clinic. V. Gardhouse and P. Murray are doing general duty at Fresno Community Hospital, Calif.

Plans have been made for the Fireside Tea for students in September and a dance and draw in aid of the Scholarship Fund and to refurnish the nurses' room at the hospital, to be held in October.

District 6

Trenton

Thirty-five members were present at the April meeting of Chapter A when Mrs. J. Haussler addressed the gathering on the subject of "World Health."

DISTRICT 7

PERTH

Bertha Griffin, retiring president of the Perth Nurses' Association, was presented with a gift of appreciation at a regular meeting of the association. It was a tribute to the painstaking care and effort Miss Griffin devoted to the affairs of the association while in office.

Plans were made for a bake sale and social evening at the next meeting.

DISTRICT 8

OTTAWA

Lady Stanley Institute Alumnae

Over 300 guests were welcomed to the Alumnae Spring Tea by the president, Mrs. J. Steele, assisted by Mrs. M. E. Jones and C. Pridmore. The guest of honor was Mrs. W. Lyman, a former superintendent of nurses of County Carleton General Protestant Hospital. Mrs. R. Gisborne ably convened the affair, assisted by other alumnae members.

DISTRICT 10

FORT WILLIAM

Word that chapters of the R.N.A.O. had been inaugurated in Dryden and Sioux Lookout by Edith Fenton, public relations secretary, was received at a regular meeting of District 10. Mrs. Garton of Fort Frances announced that 50 nurses had attended the meetings held on A.B.C. warfare and it was likely that a chapter would soon be formed in that vicinity. B. Stewart, Dryden Chapter chairman, reported on their meeting and Mrs. M. Cole discussed the Sioux Lookout Chapter. H. Wilson, Kenora, discussed the nursing activities in that area, stating that around 30 members attended the meetings.

The constitution of the Bursary Fund to aid needy student nurses, as presented by Miss Connelly, was discussed and passed. M. Flanagan and D. Adams reported for the private duty and public health nursing committees.

McKellar Hospital

At the Easter Tea held by the alumnae in April the committee was convened by Mrs. J. Gill, guests were welcomed by S. Davidson and A. Malmborg, while the hostesses were: F. Hamm, E. Hubman, Mrs. C. Bowles. Others assisting were: Mmes L. A. Remus, J. R. Sproule, R. V. Johnston, W. P. Hogarth, L. Marcotte, B. Seed, J. Currie, H. Peterson, Z. Fedori, D. Easton, J. Markham, L. Salini, E. Watkinson, A. Lenardon, F. Eberts, R. C. Bull, L. Poulter, R. Byce, J. Wishart, B. McConnell, J. Semelluk, D. Higginbottom, A. Payette, H. Boldt, S. Wallace, H. Gillman, A. Oja,

J. Johnston, L. Stanfield, D. McLeod and Misses W. Ballantyne and I. Otway.

A cake donated by Mrs. E. Korkola was won by Mrs. Leborn.

PORT ARTHUR

General Hospital

At a meeting of the alumnae association, plans were finalized for a Spring Tea, with Mrs. W. Lowcock as convener. M. O'Rourke was chosen as delegate from the alumnae to the R.N.A.O. annual meeting in Toronto. Fifteen dollars was voted towards the student nurses' Year Book. The president, Mrs. M. Rutherford, was in the chair and later refreshments were served by Mrs. W. Pertulla and R. Morhouse.

St. Joseph's Hospital

Following the alumnae meeting with C. Connelly in the chair, the annual dinner took place when Mrs. H. Chase said Grace. Mrs. W. Geddes expressed the thanks of the members to the Auxiliary for the excellent meal, after which cards were played. The prizes, donated by Mmes M. Lees and D. Commuzzi, were won by Mmes I. Purvis and A. Hague.

Conveners for the Nightingale Ball will be B. Zores, J. Gerard, and D. Tother.

PRINCE EDWARD ISLAND

The last week in March was set aside as Student Nurse Recruitment Week during which there were talks by nurses; an "at home" at the three schools of nursing with tours of the hospitals; newspaper articles; window displays and radio announcements. It is planned to continue the recruitment program throughout the year with talks to high schools in the rural areas and at meetings of the Women's Institutes.

SUMMERSIDE

At the bi-monthly meeting of Prince County District with Helen Schurman presiding, a nominating committee was appointed. The guest speaker was Mr. F. W. Jelks, bacteriologist from the Provincial Laboratory, Charlottetown. His explanation of various laboratory tests, their purposes and significance, was most instructive and interesting to all.

QUEBEC

MONTREAL

Royal Victoria Hospital

At the April meeting of the alumnae association a most interesting lecture by Dr. P. Hill on "Infectious Hepatitis" was followed by an enjoyable social hour.

Helene Lamont will represent the hospital and alumnae at the I.C.N. meetings in Brazil. E. Flanagan will also attend. E.

McNab, who resigned as supervisor of the admitting office, was presented with a gift and is now on the staff of the McGill Health Service. M. Langley was a recent visitor on her way to England and the Continent. A. Muggah has resigned from the staff of the Ross Memorial. P. Murray is with the National Institutes of Health, Bethesda, Md.

Quebec City

Jeffery Hale's Hospital

Nineteen members of the alumnae association were present at a meeting when Mrs. Kennedy was chosen delegate to the A.N.P.Q. annual meeting and an interesting talk on Korea was given by Matron M. Doddridge.

At the social hour, Mrs. Simons was the lucky winner of the raffle. Half of the proceeds of the successful rummage sale are to be used as a flower fund and the remainder to be donated to the English Chapter of District 9.

Miss B. A. Beattie, who has resigned as superintendent of nurses, was honored by the alumnae at a tea held at the Winter Club. Miss Goodday has resigned from the x-ray dept. to be married while Mrs. C. Davidson has returned to her position in the O.P.D. after three months' leave of absence.

SASKATCHEWAN

Saskatoon

The executive members of Saskatoon Chapter were guests of Alice Hazen at a meeting held at the School for the Deaf.

City Hospital

The student nurses held a tea and bazaar recently, the 1954 class being in charge. Welcoming the guests with Mrs. H. A. Armstrong were: J. Brown, N. May, I. Hewitt, J. Lindsay. The tea honors were performed by: Mmes L. T. Muirhead, G. W. Kinsman, A. A. Scharf, B. J. Reilly, F. H. Williams. Mrs. E. Clark won the door prize.

Mrs. T. H. Smith entertained at her home in Victoria for S.C.H. graduates now residing in that city. The honored guest was Mrs. E. Esson, former director of nurses at the hospital, who has returned after three and a half years in Europe associated with the Canadian Department of Labor. She received a corsage while Marion (Grant) Downer, formerly with the city health department in Saskatoon, was presented with a gift of china. Mrs. R. C. Ellis assisted the hostess while Mrs. W. J. Pulley poured tea. Others present included: Mmes S. White, T. Rayson, G. Moody, J. Davidson, G. Leedham.

New members on the staff are Mmes A. Greenhalgh and A. Coleman.

St. Paul's Hospital

Concluding the educational program for staff nurses this year, Mr. John Diefenbaker addressed both graduates and students on "The World of Today Facing the Challenge of Communism." A Civil Defence course is being conducted by M. Mackenzie, nursing arts instructor.

H. Keeler, provincial adviser to schools of nursing, talked to the students recently on "Professional Adjustments." H. Hauber has succeeded L. Weninger as president of St. Paul's Sodality.

Saskatoon Sanatorium

The extended affiliation course in tuberculosis nursing has been in effect since the beginning of the year. E. Pearston is responsible for the teaching and supervision of the student nurses who come from the schools of nursing in Saskatoon and Prince Albert.

The following have joined the staff: D. Hyrhorkiw, F. Quinlon, M. Ferguson, M. Anderson, Mrs. Enns. I. MacDonald has resigned from the general duty staff to return to her home at Eston.

Positions Vacant

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Director of Nursing for Kitchener-Waterloo Hospital, Kitchener, Ont., having capacity of 400 beds, including 71-bed chronic wing. Position would include over-all supervision of nursing & education with Associate Director of School of Nursing (94 students) & asst. in nursing service. Apply, stating qualifications & experience, to Administrator.

Director of Nurses & Principal of School of Nursing for 117-bed General Hospital. Post-graduate course in administration or equivalent experience required. Salary open. Suite in modern residence. Construction of new 150-bed hospital under way. Apply, giving details of education, qualifications, experience, enclosing recent photo. Administrator, Jeffery Hale's Hospital, Quebec City, Que.

Nursing Arts: Clinical Instructors for 208-bed Pediatric Hospital. School of 90 students & approx. 40 affiliates. Good salaries & personnel policies. Apply, stating qualifications, Director of Nurses, Children's Hospital, Halifax, N.S.

Clinical Instructors in Medicine, Surgery & Pediatrics. Positions available this summer at Misericordia Hospital, Edmonton, Alta. Good personnel policies. 44-hr. wk. Address applications & requests for further information to Director of Nursing.

Supervisor of Nurses for Halton County Health Unit. Salary according to qualifications & experience. Car allowance. Blue Cross Hospital Plan. Apply Dr. A. F. Bull, Director, Halton County Health Unit, Milton, Ont.

Supervisor of Nurses for generalized program with Bruce County Health Unit. Minimum salary: $3,000 with allowance for experience. Pension & Blue Cross Plans available. 4 wks. vacation. Car provided if required. Apply T. H. Alton, Sec.-Treas., Bruce County Health Unit, Walkerton, Ont.

Clinical Supervisor (qualified) for Jeffery Hale's Hospital, Quebec City, Que. For details apply Director of Nurses.

Clinical Supervisor for Psychiatric Unit, University of Alberta Hospital. Salary: $225 per mo. plus meals & laundry. 11 statutory holidays. 31 days vacation. Cumulative sick leave. Pension plan. Apply Director, School of Nursing, University of Alberta, Edmonton, Alta.

Night Supervisor, General Duty Nurses & Grace Graduates. Three 8-hr. shifts, alternating weekly. Good personnel policies covering vacation, hospitalization & sick time. Apply Supt., Queens General Hospital, Liverpool, N.S.

Asst. Night Supervisor & Registered General Staff Nurses for Communicable Disease hospital. Apply Acting Supt. of Nurses, Alexandra Hospital, 230 Charron St., Montreal 22, Que.

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Director of Nursing, General Hospital, Woodstock, Ontario.

Asst. Administrative Supervisor for Operating Rooms for University of Alberta Hospital. Salary: $225 per mo. plus meals & laundry. 44-hr. wk. 11 statutory holidays. 31 days vacation. Cumulative sick leave. Pension plan. Apply Director, School of Nursing, University of Alberta, Edmonton, Alta.

Clinical Instructor (qualified) by July 15. Salary: $240. **Evening Supervisor** (6:30 p.m.-12:15 a.m.) by July 1. 44-hr. wk. made up by relieving night supervisor. Salary: $240. **Night Supervisor** (12:15-7:00 a.m.) by July 1. 44-hr. week made up by relieving evening supervisor. Salary: $235. **Head Nurse** by July 1 (preferably with pediatric training) for 16-bed children's ward. Salary: $225. **Asst. O. R. Supervisor** by July 1. Salary: $220. **Head Nurse** for 27-bed Private Wing by Aug. 1. Salary: $225. **General Staff Nurses** for medical, surgical & obstetrical floors. Salary: $195-205 gross, depending on experience. 44-hr. wk. 2½ days holidays per mo. cumulative to 30 days. $30 charge for room & board. For 177-bed hospital with Training School. Apply Mrs. M. Alexander, Acting Director of Nursing, General Hospital, Medicine Hat, Alta.

Public Health Nurse for generalized program with Bruce County Health Unit. Minimum salary: $2,400 with allowance for experience. Pension & Blue Cross Plans available. 4 wks. vacation. Car provided if required Apply T. H. Alton, Sec.-Treas., Bruce County Health Unit, Walkerton, Ont.

Public Health Nurses (qualified) for Peel County Health Unit. Generalized public health nursing program. Salary schedule: $2,400-3,000. Car allowance. Unit area near Toronto. Workmen's Compensation, sick leave, Blue Cross. For full details apply Dr. D. G. H. MacDonald, Medical Officer of Health, Court House, Brampton, Ont.

Registered Nurses for General Staff for 21-bed hospital. Salary: $160 per mo. with $5.00 increase every 6 mos. to maximum of $180 per mo. Room, board & uniform laundry provided. Rotating shifts, 48-hr. wk. Blue Cross Plan, 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, General Hospital, Espanola, Ont.

Registered General Duty Nurses immediately for active 31-bed hospital. Comfortable living accommodation. Gross salary: $200 less $35 for full maintenance. 3 wks. vacation after 1 yr. Apply Supt., Little Long Lac Hospital, Geraldton, Ont.

Registered Nurses for General Duty for new hospital of 150-beds & 40 bassinets which will open this summer. Personnel policies may be obtained from Director of Nursing, South Waterloo Memorial Hospital, Y.M.C.A. Bldg., Galt, Ont.

Registered & Graduate Nurses for General Duty in 100-bed hospital with complete new Obstetrical Unit. Apply, stating experience, references, etc., Supt., The Cottage Hospital, Pembroke, Ont.

Graduate Nurses for 400-bed Thoracic Surgical Centre & Sanatorium; Charge or Asst. Charge Nurses; General Duty Nurses for rotating day duty, evening duty (3:00-11:00 p.m.) & night duty (11:00 p.m.-7:00 a.m.) 5½-day wk. Full maintenance provided. Sick leave & vacation after 1 yr. service. Annual increments. Blue Cross benefits. Superannuation. Apply Director of Nursing, Nova Scotia Sanatorium, Kentville, N.S.

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Graduate Nurses for completely modern West Coast hospital. Salary: $230 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Nurses—Staff & administrative, supervisors. Excellent opportunities. Apply International Employment Agency, 531 E. Grand Blvd., Detroit 7, Michigan.

Hospital Supt. Must be Registered Nurse with Hospital Administration experience for 50-bed hospital with Training School. Full maintenance. 4 wks. vacation with pay. Sick leave. Apply, stating salary expected, Chairman, Board of Trustees, Carleton Memorial Hospital, Woodstock, N.B.

Asst. Supt. of Nurses by Sept. 1 for Provincial Mental Hospital, Ponoka, Alta. 1,450-bed active treatment hospital conducting an accredited School of Nursing. Excellent holiday, sick leave & pension benefits. Apply, stating qualifications, experience & year of graduation, to Supt. of Nurses.

Educational Director for School of Nursing of 200 students. Post-graduate experience preferred. For further information apply Director of Nursing, City Hospital, Saskatoon, Sask.

Nursing Arts Instructor for 160-bed General Hospital. 65 students enrolled. Minimum monthly salary: $255. 44-hr. wk. 4 wks. vacation. 7 statutory holidays. Pension plan. Apply Director of Nursing, Public General Hospital, Chatham, Ont.

Science & Nursing Arts Instructors. New hospital to open this summer. Salaries depending on qualifications & experience. For full particulars apply Supt., Charlotte County Hospital, St. Stephen, N.B.

Obstetrical Supervisor & Surgical Clinical Instructor with special preparation. Gross minimum salary: $240 — annual increments, vacation, sick time. 48-hr. wk. For further details apply Supt. of Nurses, General Hospital, Moose Jaw, Sask.

Operating Room Supervisor (special preparation preferred). Also **Dietitian & Night Supervisor** for 100-bed hospital. Salary depends on qualifications & experience. Apply Soldiers' Memorial Hospital, Campbellton, N.B.

Clinical Instructor in Surgical Nursing for School of Nursing, duties to commence in early Fall. Salary open. Apply Supt. of Nurses, General Hospital, Regina, Sask.

Instructor for position of tutor in basic sciences at Regina Centre of Centralized Lecture Program for Nursing Students. This is a new program involving 8 Schools of Nursing financed by W. K. Kellogg Foundation. Good salary & personnel policies. Apply, stating qualifications, to 401 Northern Crown Bldg., Regina, Sask.

Clinical Instructor for Operating Room & Operating Room Nurses immediately. Apply Director of Nursing Service, Holy Cross Hospital, Calgary, Alta.

Asst. Director of Nurses & General Duty Nurses. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

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The Vancouver General Hospital requires:

(1) ***General Staff Nurses.*** 40-hr. week. Salary of $226.50 as minimum and $263.25 as maximum, plus shift differential for evening and night duty.

(2) ***Instructors*** with University training in teaching and supervision. Salary of $259.50 as minimum and $296.25 as maximum.

Temporary residence accommodation is available.

Applications should be accompanied by letter of acceptance of registration in B.C. from *Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.*

Apply to: **Personnel Dept., General Hospital, Vancouver 9, B.C.**

Supervisors (3), Head Nurses (3) & General Staff Nurses (14) for new unit, Civic Hospital, Ottawa, Ont. Apply Director of Nursing.

Operating Room & Maternity Nurses. Salary: $162.50 for recent graduates, 2 meals, laundry. 8-hr. day, 44-hr. wk.—straight shift. $15 differential evenings—$10 nights. Vacation, sick time & statutory holidays on salary. Semi-annual & annual increments. Financial recognition for yrs. of experience, post-graduate or university study. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

Operating Room Nurses for new 40-bed Pediatric Hospital. Some experience required. 40-hr. wk. Starting salary: $275. Apply Director of Nurses, Mercy Hospital, Sacramento, California.

Caseroom Nurses (experienced) who must be able to register in B.C. 5-day wk. & excellent personnel policies. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Public Health Nurses (bilingual) for generalized program in County Health Unit, 60 miles from Ottawa & Montreal. Car provided or allowance on privately owned car. Minimum salary: $2,400. Apply Medical Officer of Health, Prescott & Russell Health Unit, Hawkesbury, Ont.

Public Health Nurses for Halton County Health Unit. Generalized program. Present minimum salary: $2,500 with adjustments for previous experience. Annual increment. Cumulative sick leave. 4 wks. vacation. Car allowance & loan if necessary for purchase of car. Apply Dr. A. G. Bull, Medical Office of Health, Halton County Health Unit, Milton, Ont.

Public Health Nurses for York County Health Unit—generalized program. Proximity to Toronto permits possibilities of urban living conditions combined with rural work. Car provided. Health & accident insurance & other attractive working conditions. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

Public Health Nurses for generalized program. Minimum salary: $2,550 with allowance for previous experience & annual increments of $120. Cumulative sick leave plan. Pension plan & Blue Cross Plan available. Interest-free loans available for purchasing cars if necessary. Liberal transportation allowance & holidays. Apply A. E. Thoms, M.D., Director, Leeds & Grenville Health Unit, Victoria Bldg., Brockville, Ont.

Public Health Nurses (qualified) for generalized public health nursing services, City of Toronto. Salary: $2,974 with yearly increments to $3,391 per annum. 5-day wk. Sick leave & pension plan benefits. Apply Personnel Dept., Rm. 320, City Hall, Toronto, Ont.

Graduate Nurses for General Operating Room & Ward Duty in 125-bed hospital. Straight 8-hr. day, 44-hr. wk. For further information apply Supt. of Nurses, Children's Hospital, Winnipeg, Man.

Registered Nurses & Male Medical Assts. for small hospital. Salary for nurses registered in Ont., $160 per mo. plus full maintenance; others, $150 until Ont. registration received. Salary for Male Assts., $75-120 per mo. plus full maintenance. Fare to $40 refunded at end of 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

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Registered Nurses (2) for General Duty at 30-bed hospital in Dryden in northwestern Ontario, the heart of a tourist's paradise. Separate nurses' residence, fully modern. Salary: $160 per mo. plus full maintenance. Salaries subject to an annual increase. 30 days vacation after 1 yr. service. Successful applicants reimbursed rail fare after 1 yr. Apply, stating age & when available, Supt., District General Hospital, Dryden, Ont.

Registered Nurses (2) for General Duty in 17-bed hospital about 100 miles from Calgary. Salary: $165 wih full maintenance. Increase of $5.00 per mo. after each 6 mos. service up to 3 increases. Transportation refunded after 6 mos. service. Usual vacation & statutory holidays. Apply Municipal Hospital, Elnora, Alta.

Registered Nurses for General Duty in busy 70-bed General Hospital. Commencing salary: $180 per mo. for 44-hr. wk. Good personnel policy. Apply Supt., Ross Memorial Hospital, Lindsay, Ont.

Registered Nurse for General Duty in 600-bed Tuberculosis Hospital, 6 miles from London, Ont. Initial salary: $175 gross, less $33 per mo. for board, room, laundry. Staff education program. Busy surgical ward. 44-hr. wk. For other perquisites — vacation, illness, pension & further information — apply Director of Nurses. Beck Memorial Sanatorium, London, Ont.

Registered Nurses immediately for 36-bed hospital in Southern Interior of B.C. 3 active doctors on staff. Salary: $210 per mo. less than 2 yrs. experience; $220 per mo. more than 2 yrs. experience — less maintenance, $45 per mo. Statutory & annual holidays per R.N.A.B.C. Hospital situated in active & recreational community. Apply, giving full particulars, Matron, Nicola Valley General Hospital, Merritt, B.C.

Registered Nurses for General Dutv in County Hospital, Huntingdon, Que. This is a small General Hospital in Town of Huntingdon, 45 miles southwest of Montreal, connected by excellent train & bus service. Pleasant working conditions. 8-hr. duty, 3 rotating shifts. Nurses' home attached to hospital. Attractive community social life. Two theatres, badminton club, skating, curling, dancing & only 8 miles from Lake St. Francis. Salary: $140 per mo. & full maintenance. 3 increases of $5.00 per mo. at 6-mo. intervals. 10 days sick leave per yr. & 4 wks. holiday. Apply Mrs. B. Grant, Matron.

Registered Nurses for General Duty in 200-bed hospital in Niagara Peninsula. Gross salary: $210; afternoons, $220; nights, $215. Increments & return train fare after 12 mos. Also **Certified Nursing Assistants.** Salary: $160. 48-hr. wk.; no broken shifts. 21 days annual vacation. 8 statutory holidays. Cumulative sick leave. Accommodation available in attractive residence. Apply Director of Nursing, County General Hospital, Welland, Ont.

Registered Nurses for General Duty in 70-bed General Hospital in San Gabriel Valley, 40 min. from Los Angeles. Close to beaches & mountains. 40-hr. wk. 2 wks. paid vacation. 6 mos. increase in salary. Paid hospital insurance. Starting salary: $235 per mo.; $10 differential for afternoons & nights; $10 differential for surgery & maternity. Write for application form Supt. of Nurses, Inter-Community Hospital, Covina, California.

Wanted!

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The Indian Health Services of the Department of National Health and Welfare requires field supervisors in the following regions:

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Requirements:

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Salaries: $2,850 to $3,270 depending upon qualifications.

Three weeks' annual leave with pay.

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Department of National Health and Welfare,
Booth Building, Ottawa, Ont.

General Duty Nurses. Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day; 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Also **Operating Room Nurse.** Salary: $184.82 per mo. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

General Duty Nurses — "You will like it here." Placement in the service of your choice in Teaching Hospital. Beginning salary: $240 per mo. for 40-hr. wk. Scheduled increases, payment for overtime, 6-hr. evening duty. $270 per mo. for night duty. Sick leave, 6 holidays, 3 wks. vacation. Residence facilities if desired. Tuition-free courses after 6 mos. service. Opportunities for advancement. Apply Director of Nursing Service, University Hospitals of Cleveland, Cleveland 6, Ohio.

General Duty Nurses for Obstetrical, Medical & Surgical Depts. Living-in accommodation available temporarily. For information apply Director of Nurses, General Hospital, Woodstock, Ont.

General Duty Nurses (2) for 15-bed hospital. Salary: $195 per mo. & full maintenance. Apply, stating date available, P. J. Rasmussen, Sec., Climax-Bracken Union Hospital, Climax, Sask.

General Duty Nurses for 611-bed General Hospital with School of Nursing. Salary: $273; increase $15 end of 1st yr.; $17 end 2nd & 3rd yr.; $19 end 5th yr. Differential of $10 for special services & p.m. & night duty. 40-hr. wk. 12 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Housing available. Apply Director of Nursing Service, General Hospital, Fresno, California.

General Duty Nurses for 135-bed modern hospital with facilities for private patients & mild psychiatric cases. Situated on east side of Detroit, close to downtown section. Good transportation. Beginning salary: $260 per mo. with 3 semi-annual increases of $5.00 ea. $15 per mo. for afternoons & $25 per mo. more for nights, above base pay. Apply Miss G. Rashleigh, R.N., Jennings Memorial Hospital, Detroit 14, Michigan.

Graduate Floor Duty Nurses for Mount Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $83 plus cost of Living Bonus. For other perquisites & further information apply Supt.

Wanted!

PUBLIC HEALTH NURSES

The Indian Health Services of the Department of National Health and Welfare requires nurses who have had a course of one year at University in Public Health Nursing.

Salaries: **$2,720 to $3,070 depending upon qualifications.**

Three weeks' annual leave with pay.

Apply:

Personnel Division,
Department of National Health and Welfare,
Booth Building, Ottawa, Ont.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital in Laurentian Mts. For further information apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Graduate Nurses for modern 50-bed hospital. Gross salary: $220 less $40 board & lodging. $10 annual increase. 10 statutory holidays. 4 wks. annual vacation. 1½ days sick leave per mo. cumulating to 36 days. Transportation allowance not exceeding $60 refunded after 1st. yr. Apply Administrator, Wrinch Memorial Hospital, Hazelton, B.C.

Graduate Nurses (1 or 2) for Silvery Slocan District of B.C. Starting salary: $210 with annual increments of $5.00 per mo. Full maintenance, $40. All statutory holidays paid. 28 days vacation after 1 yr. service. Usual sick leave. Apply Miss A. N. Pow, Supt. of Nurses, Slocan Community Hospital, New Denver, B.C.

Attention! Graduate Nurses! Would you like to see the West or another part of your country? There are vacancies for summer relief & permanent nurses on our staff. 50-bed active modern hospital, 1 hr. from Vancouver. Accommodation available in modern residence; individual rooms. Basic salary: $220 if registered in B.C. Other R.N.A.B.C. personnel recommendations in effect. Apply Miss M. R. Ward, Supt. of Nurses, Langley Memorial Hospital, Murrayville, B.C.

Dietitian (qualified) for Teaching Hospital. Opportunity for advancement. Full maintenance. Fare from Canada for accepted candidate. For full particulars, write, giving qualifications & date available, Matron, King Edward VII Memorial Hospital, Bermuda.

National Supervisors required by the **Victorian Order of Nurses for Canada** in Nova Scotia and Ontario. Qualifications include at least three years of Victorian Order service, a demonstrated ability of successful relationships with staff and Board members & a willingness to travel. Post-graduate preparation in Supervision desirable. Salary considered in relation to individual applicant. Apply by June 30, 1953, to Chief Superintendent, Victorian Order of Nurses for Canada, 193 Sparks St., Ottawa 4, Ont.

Director of Nursing for 66-bed hospital (expanding to 156 this Fall) in Sault Ste. Marie, Ont. Private suite. Salary: $225 per mo. & full maintenance, adjusted on completion of new building. On St. Mary's River. Beautiful vista, invigorating air, no hay fever. Apply Mr. A. G. Middlemiss, Supt., Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.

Asst. Supt. of Nurses, preferably with administrative training & experience. Salary: $280. **Graduate Nurse** with **Pediatric** experience. Salary: $235 with B.C. registration. R.N.A.B.C. agreement. New 111-bed hospital. Apply Supt. of Nurses, West Coast General Hospital, Port Alberni, Vancouver Island, B.C.

Asst. Director with post-graduate experience, **Night Supervisor** (11:00 p.m.-7:00 a.m.) & **Asst. Head Nurses** for 60-bed Pediatric-Orthopedic Hospital. Also **Operating Room Supervisor** (fully experienced). Apply, stating qualifications & experience, Director, Shriners' Hospitals for Crippled Children, Montreal 25, Que.

Nursing Arts Instructor; Ward Supervisors for Surgery, Obstetrics & Pediatrics (qualified). Positions available at School of Nursing, General Hospital, Dauphin, Man. Address applications or requests for further information to M. D. Pearson, Supt. of Nurses.

The SELECTIONS COMMITTEE of the

CANADIAN NURSES' ASSOCIATION

is seeking further appointments to the

Professional Nursing Staff of National Office.

For application forms and additional information, please write to:

Miss M. Pearl Stiver, General Secretary-Treasurer,

Canadian Nurses' Association, Suite 401, 1411 Crescent St., Montreal 25, Que.

Nursing Arts Instructor for School of Nursing. 150 students—450-bed hospital. Apply Director of Nursing, General Hospital, Saint John, N.B.

Science Instructor, Nursing Arts & Clinical Instructors immediately for 208-bed Pediatric Hospital. New wing opening in Sept. Nursing School of 90 students & 40 affiliates. Good salaries & personnel policies. Apply, stating qualifications, Director of Nurses, Children's Hospital, Halifax, N.S.

Clinical-Surgical Instructor for 200-bed hospital. Particulars on application to Sister Superior, Supt., Providence Hospital, Moose Jaw, Sask.

Instructor for Students (qualified) by Aug. 1. Affiliation course. Sanatorium in Southern Ontario. Apply, stating qualifications & experience, c/o Box P, The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

Victoria, Australia—Sister-Tutors (Instructors in Nursing Arts, etc.). Several vacancies exist for Sister-Tutors, preferably qualified, in country & city hospitals in Victoria. Assisted passages with contract available. Details from Sec., Hospitals & Charities Commission, 61 Spring St., Melbourne, Australia.

Supervisor (experienced) interested in teaching & administration of hospital serving Extended Illness (516 beds). (Graduate & Nursing Aide staff.) Salary depending on qualifications. Apply Supt., Queen Elizabeth Hospital, 130 Dunn Ave., Toronto 3, Ont.

Night Supervisors for Obstetrical Division & General Duty Nurses for private wards, pediatric depts. in 400-bed General Hospital with Training School. 44-hr. wk. 30 days vacation after 1 yr. All statutory holidays. Residence accommodation available if desired. Good salary. Hospital pleasantly situated, overlooking active industrial city, 65 miles southwest of Toronto. Apply Director of Nursing, General Hospital, Brantford, Ont.

Public Health Nurses (2) for Lennox & Addington County Health Unit. Present minimum salary: $2,400. Suitable adjustments made in salary for experience. Car allowance on mileage basis. 4 wks. vacation. 5½-day wk. Cumulative sick leave at rate of 1½ days per mo. Apply Dr. J. I. Jeffs, Lennox & Addington County Health Unit, Memorial Bldg., Napanee, Ont.

Registered Nurse for Compton County Protestant Schools. Location—Cookshire, Que. Experience in Public Health Nursing an asset. Duties to commence in Aug. For full information apply immediately to W. W. Roberts, Supervisor of Schools, Cookshire, Que.

Registered Nurses for General Duty in small General Hospital. Salary: $150 per mo. with full maintenance. 6-day wk., 8-hr. duty—rotating shifts. 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holidays after 1 yr. service. Summer bonus for nurses working July, Aug. & Sept. Paid overtime. **O. R. Nurse** by July 15. Salary commensurate with training. Apply Acting Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses (2) for General Duty by July 1. 33-bed hospital. 40-hr. wk. 1 mo. vacation per yr. Gross salary: $200 per mo. & laundry of uniforms. Separate nurses' home. 18 days sick leave per yr. One-way transportation money refunded after 12 mos. service. Yearly increments. Beautiful scenery with mountain & rivers, ideal for nature lovers. Fishing, hiking, etc. Pleasant climate. Apply, with full particulars as to experience, etc., Administrator, St. Bartholomew's Hospital, Lytton, B.C.

General Duty Nurses. Salary: $210 per mo. 8-hr. day. Also **Instructor.** Salary: $230. Apply Mrs. J. S. Harry, Supt. of Nurses, Victoria Hospital, Prince Albert, Sask.

General Duty Nurses for new 75-bed hospital. Beginning salary: $260 per mo. for 40-hr. wk. $30 additional for 3-11 p.m., $20 additional for 11-7 a.m. 2 wks. vacation with pay. 7 holidays. Apply Director of Nursing Service, Mercy Hospital, Redding, California.

Graduate Nurses for General Duty—days. Also 3-11 p.m., 11 p.m.-7 a.m. 70-bed General Hospital in Westchester County, approx. 25 miles from New York City. Liberal salary, yearly increment, maintenance, vacation & sick leave. Apply Administrator, Tarrytown Hospital, Tarrytown, New York.

General Duty Nurses & Certified Nursing Asats. for 107-bed modern hospital. Starting salary for nurses: $175 per mo. plus meals & laundry. Differential for evening & night duty. Periodic increases. Travelling expenses from point of entry into Ont. refunded after 6 mos. service. 44-hr. wk. 8 statutory holidays. 21 days holidays with pay. Cumulative sick time. Medical & hospital plan subsidized. Room accommodation available in residence. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

Nurse for fully modern 13-bed hospital. Salary: $185 plus maintenance. Apply Sec.-Treas., Union Hospital, Lucky Lake, Sask.

Registered Nurses. Opportunities available for positions with Sanatorium Board of Manitoba. Salary range: $200-230 per mo. depending on qualifications & appointment. Board, room, laundry supplied for $39 per mo. Good hours & working conditions. Generous vacations, group insurance, all statutory holidays & other employee benefits. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

Director of Nursing for 121-bed new hospital. Apply, stating qualifications & full particulars in first letter, Administrator, Burnaby General Hospital, Ingleton Ave., South Burnaby, B.C.

Operating Room Nurse for modern 100-bed hospital. Gross salary: $225 plus $5.00 for call plus $10 for P.G. or credited experience; less $52.50 maintenance. Non-B.C. Registered Nurses receive $10 less. Annual increments. Contract in conformity with R.N.A.B.C. personnel practices. Apply Supt. of Nurses, Chilliwack Hospital, Chilliwack, B.C.

Nurse (1) with O.R. experience — salary: $230 per mo. & **General Duty Nurses** for 110-bed hospital. Starting salary: $220 per mo. for B.C. Reg. with annual increase up to $25; less $52.50 for board, room, laundry. 18 days cumulative sick time annually. 28 days vacation after 1 yr. 10 statutory holidays. Excellent golf, swimming, skiing & other recreational facilities. Apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

Registered Nurse for Nursery Supervisor. 56-bed hospital. Day duty. 6-day wk., 8-hr. day. Apply Director of Nursing Services, Salvation Army Grace Hospital, Ottawa, Ont.

Public Health Nurses for Wellington County Health Unit for generalized public health nursing program. Good personnel policies & working conditions in effect. Details may be obtained through contact or by writing Director of Public Health Nursing, Wellington County Health Unit, Fergus, Ont.

Public Health Nurse for Chatham Board of Health. Present minimum salary: $2,400 & adjustment for previous experience. Annual increment, pension plan, generous sick leave. Apply Chatham Board of Health, Harrison Hall, Chatham, Ont.

Registered Nurses for General Duty in 150-bed General Hospital. 44-hr. wk. 8 statutory holidays. 21 days annual vacation. For other perquisites & further information Apply Director of Nursing, General Hospital, Brockville, Ont.

Registered Nurses for General Staff for General Hospital, Parry Sound, Ont. (in heart of tourist district (Salary: $170 for days; evenings $10 extra & nights $5.00 extra. Plus full maintenance in nurses' residence. 48-hr. wk. 2 wks. vacation plus 8 statutory holidays. Increment for first 2 yrs. Apply Director of Nurses.

POSITIONS VACANT

Registered General Duty Nurses for 50-bed hospital in town attractively located on Lake Ontario, close to Toronto. 44-hr. wk. Good personnel policies. Living-in accommodation. Salary: $180 & $190 per mo. Apply Supt., General Hospital, Cobourg, Ont.

Day Supervisor capable of assuming responsibility as **Asst. Supt.** for 50-bed General Hospital in town on Lake Ontario, close to Toronto. 44-hr. wk. Apply, giving full particulars as to age, qualifications, experience & references, Supt., General Hospital, Cobourg, Ont.

Registered Nurses for General Hospital, Quesnel, B.C. Quesnel is friendly town in famous Cariboo District. Seasonal changes create vacancies for General Duty Registered Nurses. Active 22-bed hospital. Starting salary: $200; $210 after 6 mos. Board & lodging, $35 per mo. Transportation allowance up to $60 refunded after 1 yr. All statutory holidays. Sick leave. 28 days vacation after 12 mos. or proportionate 6 mos. Apply Administrator.

Registered Nurses (2) immediately for modern 8-bed hospital. Salary: $175 per mo. plus full maintenance, 3 wks. vacation after 1 yr. service. Apply Matron, Memorial Union Hospital, Maryfield, Sask.

Registered Nurses for modern addition of Norfolk General Hospital, Simcoe, Ont. Excellent salary. Rotating shifts. 7 statutory holidays. Free hospitalization. 14 days sick leave. Semi-annual & annual increments. Recognition for post-graduate study. Apply Director of Nursing.

Registered Nurses for modern 110-bed hospital in attractive town offering good facilities for summer & winter sports. Salary for general duty: $125 per mo. Complete maintenance & uniform allowance. Apply Supt. of Nurses, Western Memorial Hospital, Corner Brook, Newfoundland.

General Duty Nurses (2) immediately. Gross salary: $210 per mo. Straight 8-hr. duty. 1 mo. holiday after 1 yr. service. Sick leave & statutory holidays. Separate modern nurses' residence. Phone or write Mrs. H. E. Ashcroft, Supt. of Nurses, Union Hospital, Hafford, Sask.

Matron (1) & General Duty Nurses (2) for 20-bed hospital in beautiful Arrow Lakes District of British Columbia. Apply, giving experience, references & qualifications, Matron, Arrow Lakes Hospital, Nakusp, B.C.

Registered Nurses for General Duty in new 30-bed active hospital in summer resort town. Salary: $185 per mo. with annual increments. 44-hr. wk. 8 statutory holidays. 21 days annual vacation after 1 yr. Apply Supt., Community Memorial Hospital, Port Perry, Ont.

Registered Nurses for General Duty in all depts. of busy 80-bed General Hospital, 30 miles from Toronto. Gross salary: $187.50 per mo. Live in. Annual increase, 3 wks. vacation, 2 wks. sick time, 7 statutory holidays. Apply Supt., York County Hospital, Newmarket, Ont.

Graduate Nurses for general Operating Room & Ward Duty in 125-bed hospital. Straight 8-hr. day, 44-hr. wk. For further information apply Supt. of Nurses, Children's Hospital, Winnipeg, Man.

THE HAMILTON GENERAL HOSPITAL

HAMILTON, ONTARIO

invites immediate inquiries for the position of

SUPERINTENDENT OF NURSES

Apply, stating qualifications and experience, to:

Chairman, Board of Governors, General Hospital, Hamilton, Ontario

Official Directory

Provincial Associations of Registered Nurses

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QUEBEC

The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec Incorporated February 14, 1920.

Pres., Mlle A. Martineau, 671 ave Ogilvy, Montréal 15; Vice-Pres. (*Eng.*), Sr. M. Felicitas, Miss H. Lamont; (*Fr.*), Sr. St. Ferdinand, Mlle G. Charbonneau; Hon. Sec., Miss M. Wheeler; Hon. Treas., Mlle E. Merleau; *Councillors*, Mlles M. Bissonnet (*Dist. 4*), A. Mailloux (*7*), M. A. Trudel (*8*), J. Gagnon (*9*), Mme M. Boisvert (*6*). The above constitute the *Executive Council* and are *Members of the Committee of Management*, together with: Mlles C. Julien, C. Samson, F. St. Pierre, L. Couet, M. Olivier, Misses V. Graham, K. Brady, C. Aitkenhead, Srs. Marie-Paul, Ste. Louise de Marillac Marcil, J. Forest. *Advisory Com.*, Misses G. M. Hall, M. S. Mathewson, E. C. Flanagan, C. V. Barrett, Miles R. Aubin, G. Lamarre, M. Lacombe, F. Verret, Sr. Valérie de la Sagesse, Mrs. J. Green. *Com. Chairmen: Institutional Nursing* (*Eng.*), Miss R. Francis, Western Div., Gen. Hosp., Montreal 25; (*Fr.*), Sr. Denise Lefebvre, Institut Marguerite d'Youville, Mtl. 25; *Public Health* (*Eng.*), Miss A. Gage, 894 Osborne Ave., Verdun, Mtl. 19; (*Fr.*), Mlle E. Merleau, Can. Red Cross, 3416 rue McTavish, Mtl. 2; *Private Nursing* (*Eng.*), Miss R. Wood, 689 Rielle Ave., Verdun, Mtl. 19; (*Fr.*), To be appointed. *Chairmen, Board of Examiners*: (*Eng.*), Miss A. Haggart, Royal Victoria Hosp., Mtl. 2; (*Fr.*), Mlle J. Trudel, Hôp. Ste. Justine, Mtl. 10. **Sec.-Registrar, Miss Winonah Lindsay. Visitor to French Schools of Nursing, Mlle Suzanne Giroux.** ***Association Headquarters, 1522 Sherbrooke St. W., Montreal 25.***

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